RECOMMENDATIONS REGARDING FUTURE DIRECTIONS IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

APRIL 30, 1996

Serial 104–47

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
25–630 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-053589-1

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
MEL HANCOCK, Missouri
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
DICK ZIMMER, New Jersey
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
JIMMY HAYES, Louisiana
GREG LAUGHLIN, Texas
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska

SAM M. GIBBONS, Florida
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
L.F. PAYNE, Virginia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York

PHILLIP D. MOSELEY, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM MCCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia

CONTENTS

RECOMMENDATIONS REGARDING FUTURE DIRECTIONS IN THE MEDICARE PROGRAM

TUESDAY, APRIL 30, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:09 p.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 23, 1996
No. HL-18

CONTACT: (202) 225-3943

Thomas Announces Hearing On Recommendations Regarding Future Directions in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on recommendations regarding future directions in the Medicare program. **The hearing will take place on Tuesday, April 30, 1996, in room 1310 Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include representatives of the Prospective Payment Assessment Commission (PROPAC), the Physician Payment Review Commission (PPRC), and the U.S. General Accounting Office (GAO). However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Two major factors have brought the issue of future directions for the Medicare program to the forefront for Congress. Foremost is the concern that rates of growth in Medicare spending continue to outstrip inflation in the general economy, and even more importantly, the recent indications that Medicare's Part A Trust Fund is deteriorating more rapidly than was anticipated in the April 1995 Report of the Board of Trustees. Secondly, the broader evolution of the American health care system toward integrated health care delivery systems has an important impact on the future of the Medicare program.

Each of the three organizations identified above have statutory responsibilities in providing non-partisan advice and assistance to the Congress. PROPAC and PPRC are required to report annually to the Congress their recommendations, within their respective spheres of responsibility, concerning the Medicare program. Both PROPAC and PPRC released public reports in March 1996 detailing a variety of recommendations concerning nearly every aspect of the Medicare program. Separately, GAO has completed and also has underway a range of studies relating to policies and operations of the Medicare program. The current work, recent reports, and recommendations of these organizations will provide the basis for their testimony at the hearing.

In announcing the hearing, Chairman Thomas stated: "Securing the future of the Medicare program is an essential objective of this Congress. The advice and recommendations of these witnesses provide an important opportunity to enter into a sensible and constructive dialogue in the Subcommittee on future directions of the Medicare program."

FOCUS OF THE HEARING:

The hearing will focus on the recommendations of the witnesses concerning future directions of the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, May 14, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order.

Today is the Health Subcommittee's meeting to discuss Medicare policy and means we have to save the program. We will hear about the latest projections which confirm the worst fears about the Medicare Part A Trust Fund.

According to the Congressional Budget Office, Medicare is in worse shape than we thought based upon what we were told last year, and its balance is declining more rapidly every day.

The witnesses today will give the Subcommittee advice and guidance on how we can not only save Medicare, but also preserve the program for future generations.

The CBO testimony will confirm that Medicare will be bankrupt by fiscal year 2001, much earlier than projected by CBO and Medicare's board of trustees just last year. As you know, the trustees had projected a Medicare surplus in fiscal year 2002 of about $4.8 billion. The CBO report indicates that in that same year, 2002, the Medicare Trust Fund will be $86 billion in deficit. That is a $91 billion swing.

Everyone, especially, I think, the President, must heed this urgent new warning about Medicare's deepening crisis. As a result of this new report, the President's existing Medicare proposal, the old $124 billion offer, is out of date, as it is based on old, overly optimistic projections, and it simply will not achieve the kind of results necessary based upon CBO numbers.

The President is about to release to the Congress the 1996 report to the Medicare board of trustees. I believe and hope that the time has come for the President to show true bipartisan leadership when he releases the trustees' report. He should update his Medicare proposal, in my opinion, to reflect the latest information, and he should submit to the Congress a new plan that would save Medicare on the same day he releases the 1996 trustees' report.

We will also do our part. At this hearing today, we will hear from the Prospective Payment Assessment Commission and its new chair. We will hear from the Physician Payment Review Commission and the General Accounting Office. Each will provide the Subcommittee their views on recent proposals to save Medicare and will highlight new areas we should focus on to both reduce the cost of Medicare and reform the program to serve its beneficiaries better.

It should be noted that the ProPAC testimony also provides new projections on hospital Medicare margins for 1996. Despite concerns raised during the development of the Medicare Preservation Act of 1995 by the hospital industry and other detractors, the report shows that hospitals on the whole are, in fact, doing extraordinarily well in terms of their Medicare business.

Further, it is of particular interest that ProPAC and the GAO, as they did in testimony last year, again, identified home health and skilled nursing facilities services as two areas where spending is continuing to skyrocket. Clearly, these services are important to Medicare beneficiaries, but testimony today also points out specific concerns in these areas which I believe we must address.

The testimony on these services is supportive of the efforts in the Medicare Preservation Act of 1995 to rein in the cost of these services through reform and a prospective payment system. Any true

reform of Medicare will include expanding beneficiary choices of coverage under Medicare.

Interestingly, the New York Times reported yesterday that the American Association of Retired Persons is moving into something similar to the Good Housekeeping Seal of Approval. The AARP will be expanding managed care programs, and the rationale offered was that their members want more choices.

The testimony from both Commissions gives us useful guidance on how to expand these choices.

In that regard, it is important to state that concern over increased Medicare spending, although critical, is far from being all that is at stake. There are major changes occurring in the American health care system, particularly relating to the evolution toward integrated care delivery and financing systems. It is our responsibility, I believe, to extract the most promising developments from this evolutionary process and consider how they can be adapted to strengthen the mission and the purposes of the Medicare Program, with the ultimate goal of creating a better Medicare for beneficiaries.

The time has come, I think, to work together to save Medicare. I hope that the President does not agree that this is an election year and, therefore, you can't deal with Medicare, as his chief spokesman, Mike McCurry, indicated, as reported in the news media. I would hope the President would choose to lead this Nation by submitting a new plan without tax increases that addresses the financial concerns evidenced by the CBO report and that can achieve a strong bipartisan agreement in both the House and the Senate.

Before welcoming our first witness, a gentleman from Connecticut, Congressman Shays, I would recognize the Ranking Member on the Committee, the gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Before I comment, I wonder what happened to my portrait. The room looks better, I must say.

Thank you for holding this hearing. Let me point out that what the CBO testimony makes clear but was not clear in your remarks—CBO's estimate of total Medicare spending shows that their estimate has declined and that we are actually spending $35 billion less than they previously estimated over the next 10 years.

It is true that the part A trust fund is heading down, but the part B portion is doing far better than expected, and the total spending picture, if one wants to give the true picture to the American public, is getting better, not worse.

As I read the ProPAC and PPRC reports, it is a good thing the President did veto the Medicare budget bill. The two reports contain certification that many of the Republican proposals would have destroyed Medicare and not saved it. The plan that was put forth by the Republicans wasn't cost containment. It was cost shifting to the beneficiaries.

The reports we will hear lay out the terrible flaws in those budget proposals—medical savings accounts, excessive cuts in safety net hospitals, balanced billing on seniors, and a budget fail-safe provision that would have destroyed the choice of doctor and hospital.

As the GAO makes clear, Medicare does need to do better, but we don't need to destroy the fee-for-service system or turn Medicare from a benefit program into a voucher program where it is every senior struggling by himself to find quality care. The trust fund is in trouble, and it is obvious the first thing we should do is not take more money out of the trust funds.

In your House-passed version of Kennedy-Kassebaum, you take out $2.6 billion from the trust fund in Medicare antifraud money over the next 6 years and spend it on medical savings accounts and other tax breaks.

The Senate version of Kassebaum-Kennedy takes a total of $20 billion in Medicare savings over the next 10 years and spends it on non-Medicare items.

The week before last, Speaker Gingrich proposed to take another $36 billion out of the trust fund over 5 years to lower taxes for wealthy seniors. You can't save Medicare by spending the trust fund money on new tax breaks.

This Committee has yet to meet in the last 2 years to discuss how we are going to save Medicare. It is like sending the board of directors for a large insurance company, which Medicare is, on a sabbatical. If, indeed, we would pledge to take Medicare savings and commit them to the trust fund, I think this Committee could very quickly extend the life of that trust fund for another 4 or 5 years until we had the time to talk about the systemic changes that must come, perhaps, in the year 2010 or 2015.

I would repeat the offer, and I can speak for the caucus, to make $124 billion in Medicare savings and add 10 years to the life of the Medicare Part A Trust Fund without making the radical structural changes, which are criticized in the two Commission reports we will hear.

So, if you are serious, we can get to work. If you want to pay for tax cuts for the rich, Medicare will continue to stay in trouble.

Chairman THOMAS. With the usual bipartisan atmosphere, the Subcommittee begins.

It is a pleasure to have the gentleman from Connecticut, Chris Shays, with us. He has been involved not just from his Subcommittee on Human Resources, but from the Budget Committee position, working on how we meet the needs of all Americans, and especially seniors.

It is a pleasure to have you with us, Chris. If you have a written statement, it will be made a part of the record without objection, and you may proceed to inform us as you see fit.

STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. SHAYS. Thank you, Mr. Chairman. I want to thank you for the opportunity to testify before this Committee and to say as the Chairman on the Task Force on Medicare and Medicaid, which looks at the macronumbers, not the micronumbers, and also as the Chairman of the Human Resources and Intergovernmental Relations Subcommittee of the Government Reform Committee, which oversees HHS for waste, fraud, and abuse, I come to you with some very strong concerns.

First, I want to say that I hope that this Committee perseveres on its efforts to save Medicare from bankruptcy and give seniors choice at the same time. You were able to come up with a plan that didn't increase copayments, didn't increase the deductible and left the premium at the same, and gave American citizens the same choice you and I have as Members of Congress. I am wondering why it is all right for Members of Congress and other Federal employees to have choice in their health care program, but we don't think seniors deserve the same kind of choice we have. I hope you persevere in providing for that choice.

I am here to speak on seven hearings that my Subcommittee on Human Resources and Intergovernmental Relations had on four specific areas dealing with Medicare and Medicaid. The four areas were on: First, criminal enforcement; second, adjustment of reimbursement rates; third, automated claims review; and fourth, centralized claims processing.

I first want to state for the record, we look at Medicare and Medicaid from the standpoint of waste, fraud, and abuse. We do not have any legislative responsibility. That is your Committee's responsibility, and I come with all the realization that we can expose, but only you can come up with the solution, and I also acknowledge that your Committee has worked many years on these issues.

I want to first compliment this Committee on dealing with criminal enforcement and inserting it in the health care reform bill that passed this House. So one of the four areas that we were focused in on, this Committee has already addressed. So I want to take the next three.

Let me say to you, and this is with no disrespect to HCFA, I am not a Member of Congress who looks to lob stones into their house. I realize under Republicans and Democrats, this has been an agency that has had many challenges and troubles, but when we had one of our first hearings on June 15 last year, we asked the HCFA Administrator, Dr. Bruce Vladeck, why it appeared so difficult to exclude dishonest providers from Medicare and why it appears so easy for excluded providers to get right back into the Medicare payment line. He responded, and this part is the quote, "as an observer in the process," and that word just blew our minds. And then not a quote, but basically, he said there was little he could do to prevent the Inspector General, the Department of Justice, from agreeing to settlements that fail to impose the exclusive remedy.

I assure you, our dismay over that response was both strong and bipartisan. He is not an observer, but I sometimes feel that HCFA thinks they are.

Dealing first with the adjustment of reimbursement rates, HCFA is reluctant to use existing statutory authority to adjust prices in a timely fashion under "the inherent reasonableness authority." I think this Committee feels that he has the authority, therefore, he should act, but this is the kind of thing that we found, and it just blows our mind.

HCFA pays $144 to $211 for home blood glucose monitors, while the monitors can be purchased for $50 at a drug or grocery store. We are paying three to four times the rate that someone could pay retail in a grocery store, and the estimate that this costs us in

Medicare, admittedly in the terms of the total dollars, over a 3-year period is $10 million, but it is $10 million just down the tubes.

HCFA on the average pays 174 percent more than the Department of Veterans Affairs for oxygen concentrators. The HHS IG estimates that if Medicare were able to pay the same price as the VA, the savings would be $4.2 billion over 5 years.

I will point out to you that the response is that when HHS does it that they are including greater services than Veterans Affairs, but the difference is too stunning, an ultimate savings of $4.2 billion over 5 years. And then just the perennial kind of problem of why a hospital bed which costs $1,000 sometimes ultimately costs Medicare $7,000 just in terms of the rental process.

We believe that HHS should be allowed to have an interim price, not go through this year of bringing forth the change in regulations, allow for there to be comment from the medical community and the providers, then to respond, and then 2 to 3 years later, we have a change in price. I mean, my God, if we are the ones paying the price, why don't we pay, and if nobody is willing to deliver at that price, then we don't get it and then we have to increase the price, but if we can buy it for less, why are we spending so much more in the case of the oxygenators, up to $4.2 billion over a 5-year period?

On the automated claims review system, this autoadjudicated prepayment screen blows my mind. We had a GAO study that points out that the contractors, the 40 contractors for Medicare part B, don't have an autoadjudicated payment screen system. So that, when they get bills submitted, a bill on a broken ankle and a chest x ray, an autoadjudicated system would throw that bill right out, and it would totally reject it.

The thing that blew our minds was that the contractors when they do it for their own health care programs use the autoadjudicated system, but when they do it for Medicare, when they don't have something at stake themselves because they just process the bills, they don't have any financial stake, they just pay the bills.

I see my time is really ending.

I just want to put out a big attention to you all, a big exclamation point that you take a careful look at the Medicare transaction system. We are spending tens of millions of dollars to unify the nine different separate regional computer systems that we have around the country, and we are trying to unify them. I think HCFA is not on top of it. I think this program is costing us a heck of a lot of dollars, and I don't know what we are going to end up with in the end.

To conclude, on these three areas, I just would encourage the Committee to look at adjustment of reimbursement rates, a lot of waste, look at the autoadjudicated claims review, and the centralized claims processing also deserves a tremendous amount of attention.

We have had seven hearings on these issues and are happy to provide any information that might be helpful to your Committee in moving forward on these issues.

I thank you, Mr. Chairman.

[The prepared statement follows:]

SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS
Christopher Shays, Connecticut
Chairman
Room B-372 Rayburn Building
Washington, D.C. 20515
Tel: 202 225-2548
Fax: 202 225-2382

STATEMENT OF REP. CHRISTOPHER SHAYS
BEFORE THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
HOUSE WAYS AND MEANS COMMITTEE
APRIL 30, 1996

In seven oversight hearings on the Medicare and Medicaid programs, the Subcommittee on Human Resources and Intergovernmental Relations of the House Government Reform and Oversight Committee, has focused on four specific areas of vulnerability to waste, fraud and abuse: (1) criminal enforcement, (2)adjustment of reimbursement rates, (3)automated claims review and (4)centralized claims processing.

Provisions strengthening criminal enforcement against health care fraud were included in H.R. 3103, the Health Care Availability and Affordability Act of 1996. Mr. Schiff and I were gratified that this committee addressed the critical need for clear criminal sanctions in the fight against fraud.

I appreciate the opportunity to testify today, and to make recommendations for the improvement of the Medicare program based on that oversight work. I will focus my remarks today on the last three areas of Medicare vulnerability.

In general, we found the Health Care Financing Administration (HCFA) is not always the aggressive trustee of Medicare resources that Congress intends. On June 15 last year, we asked HCFA Administrator Dr. Bruce Vladeck why it appeared so difficult to exclude dishonest providers from Medicare; and why it appears so easy for excluded providers to get right back into the Medicare payment line. He responded that "as an observer in the process" there was little he could do to prevent the Inspector General and the Department of Justice from agreeing to settlements that failed to impose the exclusion remedy. I assure you, our dismay over that response was both strong and bipartisan.

Expanded mandatory exclusion and more aggressive use of permissive exclusion authority should be elements of any Medicare protection legislation, and I am pleased to note that both House and Senate health care bills contain stronger exclusion provisions.

1. Adjustment of Reimbursement Rates

But HCFA's reluctant or lethargic use of existing statutory authority to protect the integrity of Medicare is also evident in their approach to adjusting reimbursement rates. In failing to adjust prices in a timely fashion under the "inherent reasonableness" authority at 42 USC 1395m(a)(10)(B), HCFA makes Medicare an attractive target for fraud.

The General Accounting Office (GAO) recently concluded that "HCFA is slow and often ineffectual in addressing problems involving overpricing ...." The Department of Health and Human Services' Inspector General (HHS IG) characterized the current price adjustment system "absurd."

The HHS IG has a laundry list of items for which HCFA has paid higher-than-market reimbursement rates:

- HCFA paid $144 to $211 for home blood glucose monitors while the monitors could be purchased for $50 at a drug or grocery store. GAO estimates that in just one instance the delay in adjusting the price of home glucose monitors cost the Medicare program $10 million over 3 years.

- HCFA, on the average, paid 174 percent more than the Department of Veterans Affairs (VA) for oxygen concentrators. The HHS IG estimates that if Medicare were able to pay the same price as the VA the savings could be $4.2 billion over 5 years.

- HCFA often pays many times more than the purchase price of durable medical equipment such as hospital beds and wheelchairs. For example, Medicare pays up to $7000 over the useful life of an electric hospital bed while the bed can be acquired for $1000.

- Medicare pays more than the lowest suggested retail price for more than 40 types of surgical dressings.

There is a way to cap this geyser. H.R. 3225 would require the Secretary to issue an interim final regulation adjusting the price for a Medicare item or service within one year of initiating the review of that item under HCFA's inherent reasonableness authority. The net effect would be more timely adjustment of Medicare reimbursement rates.

Some suggest that the delay in adjusting reimbursement rates can be fixed administratively by streamlining HCFA's internal review process. But statutory restrictions on the use of the adjustment authority give HCFA all the excuses needed to avoid the use this important tool. Therefore a legislative remedy is necessary to counter HCFA's reluctance to launch the current time-consuming and expensive process.

2. Automated Claims Review

Better management of Medicare contractors could also dramatically enhance our first line of defense against Medicare fraud and abuse. In February this year, our subcommittee heard testimony that HCFA is failing to require Medicare Part B contractors to use computer software capable of screening out claims for inappropriate or widely overused medical services. Called "autoadjudication prepayment screens," this software compares the physician diagnosis to the treatment or service provided.

For claims that do not meet established criteria, the software can automatically deny payment, or suspend payment and subject the claim to further review. As a result, savings are captured on seventy-five percent of the claims initially denied or suspended by this technology.

For example, if the diagnosis is chronic pulmonary heart disease the software would allow payment for an echocardiogram but not for a colonoscopy. Failure to use this software means Part B contractors may be routinely paying claims that do not meet the test of medically necessity.

At the request of the subcommittee, GAO surveyed 17 Medicare Part B contractors to determine which contractors were using the medical necessity prepayment screens. GAO testified their survey revealed only 7 of the contractors were utilizing this commercially available software. For just the six groups of commonly prescribed services reviewed, GAO estimates use of this software could save up to $200 million.

GAO concluded that "[p]roblems with controlling payments for widely overused procedures persist because HCFA lacks an effective national strategy. Although the need for national leadership is compelling, HCFA has not exercised its statutory authority to take an active role in promoting more local medical policies and prepayment screens for widely overused services." GAO concluded HCFA should focus more of its fraud prevention efforts on these autoadjudication prepayment screens.

Incredibly, HCFA seems to be moving in the opposite direction. While more and more claims are flowing through the system, fewer and fewer claims are being screened. Despite a 32.5 percent increase in claims and a $54 billion increase in outlays between fiscal years 1991 and 1995, medical review as a percentage of Medicare outlays declined from .15 percent to .08 percent.

Although H.R. 3103 and S. 1028, the Health Insurance Reform Act of 1995, both include provisions to require third-party review of Medicare claims to detect fraud, those provisions do not fill the void noted by GAO for medical standards to guide those private contractors in screening for fraudulent or inappropriate claims. Screening guidelines should be established to ensure Medicare does not continue to pay claims for medically unnecessary services.

3. Centralized Claims Processing

In a November 16 joint hearing with the Subcommittee on Government Management, Information and Technology, our subcommittees found HCFA is endangering its Medicare Transaction System (MTS) project by its lack of a disciplined management process. The lack of a disciplined management process means the MTS project may not be able to achieve its goals of improved beneficiary service, improved information services to beneficiaries, providers and the government and improved fraud prevention.

HCFA's answer to these near-term vulnerabilities is the long-term, unified claims system under development - the Medicare Transactions System (MTS). HCFA rightly points to the MTS system as a potentially powerful tool to prevent and detect Medicare fraud. Once operational, the MTS could identify suspicious billing activities by processing claims through a single, integrated automated system. In his testimony, Dr. Vladeck reported "a single unitary national provider file... in concert with the implementation of MTS [would allow HCFA to] process claims in a way that can cross-reference national claims on a real-time basis."

However, whether the MTS will deliver the benefits of advanced data processing to Medicare, or whether it will succumb to the delays and design flaws that so often doom government computer acquisitions to early obsolescence, is still unclear. Nor is it clear whether the goals, deadlines and cost estimates for the MTS are realistic. But it is clear that HCFA is missing important near-term opportunities to enhance Medicare while placing all its hopes on the MTS project.

GAO found significant weaknesses in HCFA's approach to the MTS that are adding unnecessary risk to the project. Specifically, the GAO review found HCFA is not fully defining the necessary functions of the MTS system while shrinking the development process. By proceeding with uncertain development criteria in a shortened development process, HCFA risks the effectiveness and capability of the final system. Defining functions is the foundation upon which all other decisions for the system will be based.

And, according to GAO, by shrinking the development process, HCFA risks significant cost overruns. The MTS project has already cost $19 million. In the FY 97 HHS budget, HCFA has requested an additional $50 million for MTS. Perhaps further appropriations for the MTS project should be withheld while HCFA demonstrates that it has addressed these serious management challenges. The American taxpayers should not be asked to fund a large government computer acquisition like MTS unless the administrating agency can demonstrate it is controlling the risks to the project.

Through the oversight work of the subcommittee I chair, we have learned that more aggressive management, and strengthened statutory tools to fight fraud, can save hundreds of millions of Medicare dollars. I believe a streamlined price adjustment authority, standardized use of medical necessity screening and reprogramming of MTS funds for current anti-fraud activities would enhance the integrity of the Medicare program.

Chairman THOMAS. I thank you very much, Chris.

To begin with where you ended, HCFA has spent about $20 million on the Medicare transaction system. They are requesting for fiscal year 1997 another $50 million.

Did any of your hearings come up with some suggestions for how the funds might be reprogrammed?

Mr. SHAYS. The answer to your question is yes, but I want to say that on my Committee, we did a joint hearing with the Government Management, Information and Technology Subcommittee by Mr. Horn, and he has really taken the lead on this particular issue. We will make sure that he provides you some information because his Subcommittee, more than mine, is focused on that.

Chairman THOMAS. We will contact the gentleman from California as well.

Mr. SHAYS. Yes.

[The following was subsequently received:]

Mr. HORN. Your testimony projects about $200 million annually in administrative savings as a result of MTS. However, GAO estimates that the Medicare fraud, waste, and abuse is 10 percent of the program, which was discussed with Chairman Clinger. By the time MTS is scheduled to be in place, this could be about $25 billion a year.

Are we placing too much emphasis in holding administrative costs down when we could save money by investing in waste, fraud, and abuse detection systems?

Mr. VLADECK. Mr. Chairman, you are playing a tune that is somewhat familiar to us. We have felt for a long time that the arbitrary separation of administrative costs and appropriated accounts from trust fund expenditures in the entitlement accounts probably caused us to underinvest in certain program integrity activities. And, in fact, the administration has proposed legislation and has worked with the congressional majority in both Houses on legislation that would permit us to develop new financing vehicles so that the savings in—some of the savings in trust fund outlays could be reinvested in administrative activities, both on our part and that of the law enforcement agencies.

Chairman THOMAS. There is no sense in having three separate Subcommittees not share information on such a delicate program.

Did I understand that Bruce Vladeck basically identified himself as an observer? Especially in terms of exercising the inherent reasonableness authority, I would tend to see him more as a participant than as an observer.

Mr. SHAYS. Let me say this to you. With all respect to Mr. Vladeck, he only said it once, and he was encouraged by both Republicans and Democrats not to say it or to think in those terms, but it did give you a mindset.

I think they feel like there are all of these rules that we have imposed on HCFA, and that they are just kind of a referee and that they can't be as proactive as I think you and I intend them to be.

Chairman THOMAS. I would just tell you that from my time here, as a matter of fact, in this Committee room dealing with House oversight in the old House administration, it was not a dissimilar situation in terms of government purchases and the price that government paid versus what people could go down to a store and purchase for a similar piece of equipment. It is not a surprise to me that this same thing is going on in the purchase of medical equipment.

When you begin adding up various areas, as you have done, and you can reach $2.5 billion by only two particular categories, the Chairman agrees with you that there could very well be a signifi-

cant savings out there. Even if there isn't, it ought to be done that way.

Mr. SHAYS. Mr. Chairman, let me just say, absolutely, I practically stake my life on it, but you will realize tens of billions of dollars of savings over a significant period of time, but certainly hundreds of millions, and the solution we think is quite simple. There is a very definite process.

We would simply allow HHS to do an interim price and have the interim price be the acting price until final determination, and it may go back up to the higher price.

Chairman THOMAS. You could do as an interim, as you say, a target price and then see how close you come to the bull's-eye.

Mr. SHAYS. Yes, exactly.

Chairman THOMAS. Thank you very much.

The gentleman from California.

Mr. STARK. I welcome our colleague.

Mr. SHAYS. Thank you, Mr. Stark.

Mr. STARK. He raises some good points. I must suggest that you didn't quite blend in these instances of high cost. Amgen, for instance, rips us off for Epo, and we are the only purchaser. We could, in fact, get a better deal there, or kidney dialysis medicine, and we don't.

It may come as a surprise to you, and I hate to say this to the gentleman from Connecticut, but HCFA and Medicare still have the most efficient operating ratio or the lowest overhead of any insurance plan in the country, about 3 percent. Also, as PPRC will testify, this past year, HCFA was paying on average 71 percent to doctors of that of the comparable pay by private payers, and HCFA was paying 97 percent of the cost for hospitals as compared to private payers who were paying 124 percent of the cost.

So, if you take the aggregate of the lowest overhead, returning about 97 cents of every dollar paid in to patients, and the fact that we are paying 70 percent of what private insurers are paying for doctors and a lower rate for hospital care, you have got to come out and say it isn't a bad system. It could be improved, and this Committee for 8 years under a different leadership, but with the cooperation of Mr. Gradison, lowered the amount that Medicare spent every year in a row on a bipartisan basis. We changed formats and we changed charging practices. It can be done.

For instance, would you join me on this? Would you support legislation that I like to call most favored nation, and we could legislate that Medicare would be prohibited from paying a provider more than what that provider charged its lowest charge in an area?

So that, if a hospital in Connecticut or an ophthalmologist did a service for a private insurance company, and certainly, we have a bigger volume than any of them, then we would be entitled to that lowest rate. Could you be comfortable with that?

Mr. SHAYS. Let me just say, conceptually, first, I would never endorse a bill I haven't seen, but let me just say, I understand the argument that we are the bull in the china shop. We are the major purchasers. So we can almost determine price, and there has to be a fairness.

Mr. STARK. No question.

Mr. SHAYS. Yes.

I accept that, but could I just qualify something?

Mr. STARK. Sure.

Mr. SHAYS. We have a gaming of the system. It just is not useful to say we may pay doctors less, for instance, for a visit. When they go to a nursing home and they spend 15 minutes and poke their head in seven rooms, they have gamed the system. So you could say on a per-visit, it is cheaper, but it is just not.

Let me just make this other point.

Mr. STARK. Could I just reclaim on that point?

Mr. SHAYS. Sure.

Mr. STARK. I would urge you to think about this—for as long as I can remember, we have felt that we should stay out of that. We, Medicare, is really an insurance company.

The minute you and I or Bill and I start determining how long that visit should be or whether the visit should exist, we are getting into an area with which we have no expertise or no staff.

Mr. SHAYS. I wasn't suggesting that. I want to clarify what I am saying.

I am just suggesting that the statistics can be very misleading. When we, in fact, impose certain things on providers, they find a way to game the system. When other people visit them and they charge a little bit more, their visit may be more substantive, but they have justified in their own minds, since HCFA is not paying them, since the government is not paying them enough, they justify in their own mind, just poking their head in and saying, "Louise, how are you doing today?," going over to see Tom and saying how are you doing, and in the end, they have made what they made. It looks great because you said they had nine visits, but they probably only spent 15 minutes. Whereas, with another patient in the private sector, they literally spent 15 minutes with that patient.

Mr. STARK. Why do you think they do that? I find that difficult to believe, besides which, if they are seniors, they are all being paid by Medicare.

Mr. SHAYS. They are gaming the system to get around rules and regulations of the Federal Government.

Mr. STARK. You don't think they do that with Pru and Aetna and the others?

Mr. SHAYS. I don't think to the extent, no, absolutely not.

Mr. STARK. I think you would find quite to the contrary. It is the same.

If they are going to game the system, have excessive tests or shortchange their visits, that type of provider is perfectly willing. As a matter of fact, the private insurance companies spend nothing on fraud and abuse. All they do is add it to the premium, and we have had testimony after testimony that they are not interested in the private sector because it is too easy just to increase the premiums and not offend a lot of people.

Mr. SHAYS. That is the old cost-plus, but when it is your dollars and you can't pass it on because you are in a competitive marketplace and you go after waste——

Mr. STARK. That is what I am talking about. In the competitive marketplace, they don't do it.

Mr. SHAYS. In my hearing, we have had the private sector testify, and there was a reason why they wanted to make health care

fraud an all-payer fraud because they say they go from State to State and they go from government to private sector, and I think they are very concerned about the waste in their system because that is where they are going to make their profit.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. I just want to thank you, Congressman Shays, for your excellent testimony, and the work that you have done as a Member of the Budget Committee has been far more indepth than any of your predecessors, myself included years ago when I served on the Budget Committee. It has been very helpful to us.

I am particularly interested in item 1 of your testimony about adjustment of reimbursement rates and HCFA's reluctance or unresponsiveness to use existing statutory authority.

I was absolutely appalled, and I am not sure of the statutory situation in this regard, but certainly, if the statute had been a problem, they could have come to us. They have let a number of automatic, very substantial increases go into effect without comment, a 12-percent increase for surgeons 1 year ago January and recently a 10-percent increase for everybody across the board, at a time when prices are declining in many of these areas. Some of those adjustments certainly could not have been justified, and I don't know whether anything your Committee has done bears on that.

Mr. SHAYS. All I can say is that I have had the sense that a lot of people in Congress feel that HCFA has been proactive in this area, and our hearings and our testimony in GAO reports basically demonstrate that they are not. They really feel that they have two bosses. They have the taxpayers and they have the health care community, and they are not kind of sure whether they are overseeing the health care community or they are kind of just in between the two.

Mrs. JOHNSON. There is more and more evidence of HCFA being a force to drive prices up rather than drive prices down.

Some years ago, they were clearly driving prices down, but they have not been looking at the specific level that you note, and there are other examples that have come to my attention that are appalling.

Mr. SHAYS. I do want to give them one out. The one out is this. Sometimes when they are too aggressive, Members of Congress representing a particular industry or particular interest in their own district, then kind of hit on HCFA. So I do want to say that they have been burned on both sides, in fairness to them, but I think the pendulum has swung too far in favor of the providers and not enough in favor of the taxpayer.

Mrs. JOHNSON. I think your point is well taken that they have often met irrational and unfair criticism from Congress. On the other hand, in an era of enormous changes, in the price structure in health care, for them not to have come back either last year or this with any recommendations about changing how we determine prices indicates to me that your comment that they are reluctant or lethargic is a pretty good description of where they are.

Thank you.

Mr. SHAYS. I thank you all because it has been a frustration for us, and it is nice to be able to voice it to the Committee that can really do something about it.

Chairman THOMAS. Chris, thank you once again and, notwithstanding the mind-boggling numbers that CBO is going to present us whenever a program is not run the way it probably should be run, we should focus on it.

Notwithstanding the Ranking Member's comment on his $124 billion proposal and the radicalness of a proposal I know you feel proud of and worked on, the President's proposal, the $124 billion, has an unprecedented $37 billion transfer from the general fund into the part A trust fund through the failure to pay the premium on the home health care funding.

So keep up the diligence. Our job is to make sure that the program is run the way it ought to be run, notwithstanding the enormous difficulty in finding the dollars that are currently needed according to the CBO report.

Thank you very much.

Mr. SHAYS. Thank you, Mr. Chairman.

Chairman THOMAS. Now it is our desire to call Dr. Van de Water. Dr. Van de Water is the Assistant Director for Budget Analysis, Congressional Budget Office.

Thank you for appearing before us. As you know, you were not originally scheduled to be part of this hearing, but based upon actions that you initiated, we thought it was appropriate that you come before us to help us better understand the change in the numbers.

I think I speak for all of us in indicating that we would have probably preferred not to have your numbers in the first instance. In the second instance, we need the most realistic numbers possible because if, in fact, this is what reality looks like tomorrow, we have to deal with it.

So, Dr. Van de Water, any written testimony you have will be made a part of the record, and you can inform us in any way you see fit.

STATEMENT OF PAUL N. VAN DE WATER, PH.D., ASSISTANT DIRECTOR, BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE

Mr. VAN DE WATER. Thank you, Mr. Chairman and Members of the Subcommittee for inviting me to be here today to discuss the financial status of the Medicare Program, particularly that of the Hospital Insurance Trust Fund.

In 1995, the last completed year, spending for Medicare benefits and administrative expenses totaled $180 billion, including both the HI and SMI, Hospital Insurance and Supplementary Medical Insurance Programs. Under current law, CBO projects that Medicare spending will double by 2003 and increase to $468 billion by 2006. That growth represents an average annual rate of increase of 9.1 percent a year over the period.

The growth in Medicare spending projected by CBO is broad-based. Hospital insurance outlays, which include spending for inpatient hospital care, home health services, skilled nursing facilities, and a share of premiums for beneficiaries enrolled in capitated

health maintenance organizations, are projected to increase at an average rate of 8.3 percent a year. Supplementary medical insurance, which pays for physicians' services, labs, durable medical equipment, and outpatient hospital services, is projected to increase at an average rate of 10.3 percent annually.

For both HI and SMI, payments to risk-based HMOs, health maintenance organizations, are the fastest growing component. Most of that growth, however, is attributable to rapidly increasing enrollment. CBO projects that enrollment in risk plans will increase 25 percent in 1996 alone, with the rate of growth slowing to 10 percent a year in 1999 and thereafter. CBO also projects that the number of Medicare enrollees in the traditional fee-for-service sector will actually decline over this period.

Despite that decline in fee-for-service enrollment, however, payments for home health, skilled nursing, and outpatient hospital services are still projected to grow at double-digit rates.

The financial transactions of Medicare are handled through two separate trust funds on the books of the Treasury. The trust fund technique involves earmarking specific taxes or other revenues to finance certain programs. That procedure helps to weigh the costs and the benefits of the programs and gives beneficiaries some assurance that their benefits will be protected.

Financial soundness is not an issue for the Supplementary Medical Insurance Program because the portion of spending not financed by premiums is covered by an open-ended appropriation from the general fund of the Treasury. The Hospital Insurance Trust Fund, however, does not have a tap on general revenues and is facing depletion within 5 years.

Last year, in 1995, spending for hospital insurance exceeded by a small amount earmarked payroll and income taxes and other income to the fund. CBO projects that outgo will exceed income by $7 billion this year. With HI outlays increasing more quickly than payroll tax receipts, the gap will widen each year, and the HI Trust Fund will become insolvent in 2001.

Over the past year, CBO has slightly modified its Medicare projections. Overall, as Mr. Stark indicated, CBO's April 1996 projections for Medicare spending are lower than its March 1995 projections. CBO has reduced its projected levels of spending for SMI. It has upped its projection for HI, and the projected insolvency of the HI Trust Fund has been moved forward by 1 year.

In March of last year, CBO projected that the HI Trust Fund would run a $3 billion surplus in 1995 and that outlays would exceed receipts beginning in 1996. In fact, outlays in 1995 slightly exceeded income to the trust fund. This change from a surplus to a deficit position has recently received a great deal of attention.

Given the size of the HI Program and the uncertainty that surrounds even short-run projections of outlays and revenues, however, that change provides little new information about appropriate directions for Medicare policy. At this point, apart from total outlays, we know very little about the details of recent developments in health benefits paid by the HI Program.

Similarly, the advance of 1 year in the projected date of insolvency confirms what we already knew, namely, that Medicare

spending continues to grow at rates significantly in excess of the payroll and other tax revenues used to pay for benefits.

As the Members of this Subcommittee recognize, fixing Medicare's financing problems will not be easy. Either taxes must be increased, expenditures reduced, or both, and the magnitudes involved are large.

To ensure solvency of the HI fund just through 2006 would require an increase in the HI payroll tax of 0.7 percentage points, about 25 percent, starting in January. Alternatively, to provide another illustration, the rate of growth of HI outlays would have to be slowed by more than 3 percentage points, from 8 to about 4.5 percent a year. Still larger changes would be required to bring the growth of SMI spending in line with the growth of the economy. Postponing action would make the necessary corrections even more severe.

That concludes my statement, Mr. Chairman. I would be happy to take your questions.

[The prepared statement and attachments follow:]

STATEMENT OF PAUL N. VAN DE WATER
ASSISTANT DIRECTOR FOR BUDGET ANALYSIS
CONGRESSIONAL BUDGET OFFICE

Mr. Chairman and Members of the Subcommittee, it is my pleasure to be here today to discuss the financial status of the Medicare program, particularly the Hospital Insurance (HI) trust fund.

Continuing growth in the cost of providing Medicare coverage to each beneficiary, coupled with a steady increase in the number of beneficiaries, is eroding the financial status of the program. Spending for Hospital Insurance and Supplementary Medical Insurance (SMI) combined has increased from 0.8 percent of gross domestic product (GDP) in 1975 to 2.5 percent in 1995. The Congressional Budget Office (CBO) projects that if current law is not changed, Medicare spending will increase to 3.8 percent of GDP by 2006. Program revenues, however, are not increasing nearly as rapidly. If left unchecked, those trends will create a problem of major proportions when the baby-boom generation begins to reach retirement age in 2010.

CBO'S BASELINE PROJECTIONS

In 1995, spending for Medicare benefits and administrative expenses totaled $180 billion, including both the Hospital Insurance and Supplementary Medical Insurance programs. Under current law, CBO projects that Medicare spending will double by 2003 and increase to $468 billion by 2006 (the last year for which CBO prepares detailed projections). That growth represents an average annual rate of increase of 9.1 percent over the 1995-2006 period (see Table 1).

The growth in Medicare spending projected by CBO is broad based. HI outlays, which include spending for inpatient hospital care, home health services, skilled nursing facilities (SNFs), and a share of premiums for beneficiaries enrolled in capitated health maintenance organizations (HMOs), are projected to increase at an average annual rate of 8.3 percent. SMI, which pays for physicians' services, labs, durable medical equipment, outpatient hospital services, and the remaining share of premiums for beneficiaries enrolled in risk plans, is projected to increase at an average annual rate of 10.3 percent.

For both HI and SMI, payments to risk-based HMOs are the fastest-growing component. Most of that growth, however, is attributable to rapidly increasing enrollment. CBO projects that enrollment in risk plans will increase 25 percent in 1996, with the rate of growth slowing to 10 percent in 1999 and subsequent years. CBO also projects that the number of Medicare enrollees in the traditional fee-for-service sector will actually decline over this period. Despite that decline in fee-for-service enrollment, however, payments for home health, SNFs, and outpatient hospital services are still projected to grow at double-digit rates. The growth in spending for those services partly reflects successful efforts to constrain the growth in spending for inpatient hospital services.

STATUS OF THE HOSPITAL INSURANCE TRUST FUND

The financial transactions of the HI and SMI programs are handled through two separate trust funds on the books of the Treasury. The trust fund technique involves earmarking specific taxes or other revenues for financing certain programs. That procedure helps to weigh the costs and benefits of the programs and gives beneficiaries some assurance that their benefits will be protected.

Financial soundness is not an issue for the SMI trust fund because the portion of spending not financed by premiums is covered by an open-ended appropriation from the general fund of the Treasury. The HI trust fund, however, does not have a tap on general revenues and is facing depletion within five years.

In 1995, spending for Hospital Insurance exceeded by a small amount earmarked payroll and income taxes and other income to the trust fund. CBO projects that outgo will exceed income by $7 billion in 1996. With HI outlays increasing more quickly than payroll tax receipts, the gap will widen each year, and the HI trust fund will become insolvent in 2001 (see Table 2).

COMPARISON WITH PREVIOUS PROJECTIONS

CBO has slightly modified its projections for Medicare over the past year. Overall, CBO's April 1996 projections for Medicare spending are lower than its March 1995 projections. Although CBO has reduced projected levels of spending for SMI, it has upped its projections for HI, and the projected insolvency of the HI trust fund has moved forward by one year.

In March of last year, CBO projected total spending of $463 billion in 2005, compared with a current projection of $428 billion. Most of the decrease stems from changes in projected spending for the SMI program. For 2005, CBO has reduced projected SMI spending from $216 billion to $173 billion. That decline reflects two factors: a lower base--actual 1995 spending was $2 billion lower than CBO's March 1995 projection--and a lower projected rate of growth. The lower projected rate of growth recognizes a slowdown in SMI spending over the past several years.

In contrast, CBO's current projections of HI spending exceed those of a year ago. In March 1995, CBO projected HI outlays of $247 billion in 2005; our current projection is $255 billion. That change primarily reflects an increase in actual 1995 outlays, which came in about $1 billion higher than CBO's original projection. Although complete information is not yet available, we attribute much of that increase to higher-than-expected hospital admissions and a change in the mix ofcases. Because it is not clear whether this trend will continue, we did not significantly change our projected rates of growth in HI outlays for the out-years.

In March 1995, CBO projected that the HI trust fund would run a $3 billion surplus in 1995 and that outlays would exceed receipts beginning in 1996. In fact, HI outlays in 1995 slightly exceeded income to the trust fund. That change reflects the higher-than-projected HI outlays noted above and lower-than-projected receipts.

CONCLUSION

The change from a surplus to a deficit in the HI trust fund in 1995 has recently received a great deal of attention. Given the size of the HI program and the uncertainty that surrounds even short-run projections of outlays and revenues, however, that change provides little new information about appropriate directions for Medicare policy. At this point, apart from total outlays, we know very little about recent developments in health benefits paid by the HI program.

Similarly, the advance of one year in the projected date of insolvency should be viewed not as telling us something new but confirming what we already know: Medicare spending continues to grow at rates signficantly in excess of the payroll and other tax revenues used to pay for benefits.

As the Members of this Subcommittee recognize, fixing Medicare's financing problems will not be easy. Either taxes must be increased, expenditures reduced, or both, and the magnitudes involved are large. To ensure solvency of the HI trust fund just through 2006 would require an increase in the HI payroll tax of 0.7 percentage points--about 25 percent--starting in January. Alternatively, the rate of growth of HI outlays would have to be slowed by more than 3 percentage points--from 8 percent to about 4½ percent a year. Larger changes would be required to bring the growth of SMI spending in line with the growth of the economy. Postponing action would make the necessary policy actions even more severe.

TABLE 1 PROJECTIONS OF MEDICARE OUTLAYS (By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Average Annual Percentage Rate of Growth, 1995-2006
Hospital Insurance	115	127	139	152	164	177	190	204	220	237	255	275	8.3
Supplementary Medical Insurance	65	72	79	88	97	106	116	128	141	156	173	192	10.3
Gross Outlays	180	199	219	240	261	283	307	332	361	393	428	468	9.1
Premium Receipts	-20	-20	-21	-23	-24	-25	-26	-27	-29	-30	-31	-32	4.3
Net Outlays	160	179	198	217	237	258	281	305	332	363	397	435	9.5

SOURCE: Congressional Budget Office

NOTE: Numbers may not add up to totals because of rounding.

TABLE 2. BASELINE PROJECTIONS OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND
(By fiscal year, in billions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
April 1996 Baseline												
Outgo	115	127	139	152	164	177	190	204	220	237	255	275
Income												
Payroll taxes[a]	104	110	117	122	129	136	142	150	157	165	173	182
Interest	11	10	9	7	5	3	b	-2	-6	-10	-14	-19
Total	115	120	126	130	134	139	143	147	151	155	159	163
Surplus or Deficit	b	-7	-13	-22	-30	-38	-48	-57	-68	-82	-96	-112
Fund Balance[c]	130	122	109	87	57	19	-29	-86	-154	-236	-332	-444
December 1995 Baseline												
Outgo	115	126	138	149	161	173	186	200	214	231	248	n.a.
Income												
Payroll taxes[a]	104	109	115	121	127	134	140	147	154	161	169	n.a.
Interest	11	10	9	8	7	5	3	b	-3	-7	-12	n.a.
Total	115	120	124	129	134	139	143	147	151	154	157	n.a.
Surplus or Deficit	b	-7	-13	-20	-27	-34	-43	-53	-64	-77	-91	n.a.
Fund Balance[c]	130	123	109	89	62	28	-15	-68	-132	-208	-299	n.a.
August 1995 Baseline												
Outgo	114	125	137	148	160	172	185	199	214	230	247	n.a.
Income												
Payroll taxes[a]	104	110	115	121	128	135	142	150	158	167	176	n.a.
Interest	10	10	9	8	6	4	2	-2	-6	-11	-17	n.a.
Total	114	120	124	129	134	140	144	149	152	156	159	n.a.
Surplus or Deficit	b	-5	-13	-19	-26	-33	-41	-51	-61	-74	-89	n.a.
Fund Balance[c]	129	124	112	93	67	34	-7	-58	-119	-194	-282	n.a.
March 1995 Baseline												
Outgo	114	125	137	148	160	172	185	199	214	230	247	n.a.
Income												
Payroll taxes[a]	106	113	118	124	131	138	145	153	161	170	179	n.a.
Interest	10	10	10	9	7	6	3	b	-3	-7	-12	n.a.
Total	117	123	127	133	138	143	148	153	158	163	167	n.a.
Surplus or Deficit	3	-2	-9	-15	-22	-29	-37	-46	-56	-67	-80	n.a.
Fund Balance[c]	132	129	120	105	83	53	16	-30	-85	-152	-233	n.a.

SOURCE: Congressional Budget Office.

NOTE: n.a. = not available. Numbers may not add up to totals because of rounding.

a. Includes a small amount of premiums and other noninterest income.
b. Less than $500 million.
c. At the end of the fiscal year.

Chairman THOMAS. Thank you very much, Dr. Van de Water.

I just want to put some statements in a proper context so that I can better understand or attempt to try to get people to focus on the magnitude of what we are dealing with.

This, I believe, is the statement of my friend and colleague from California. The Democrats repeat their offer to make $124 billion in Medicare savings and add 10 years to the life of the Medicare Trust Fund. My problem was, this morning, I was doing some math on our "position," which has been characterized by the gentleman as more significant and robust than theirs, and I believe that the balanced budget amendment falls short of these current numbers, as projected by the CBO.

How in the world, then, could the gentleman from California repeat his offer of $124 billion in Medicare savings and add 10 years to the life of the Medicare Trust Fund? Are you familiar with the President's proposal, which I assume is $124 billion?

Mr. VAN DE WATER. We certainly have done estimates on the administration's proposal.

Chairman THOMAS. Based upon the new numbers that you have looked at, would that add 10 years to the Medicare Trust Fund?

Mr. VAN DE WATER. No, it would not. As my statement indicated, under current law, we project that the HI Fund would become insolvent in 2001. Under the administration's policies, as best we can tell, CBO suspects that the fund would become insolvent in 2005. So it would add 4 years to the life of the fund.

Chairman THOMAS. So, basically, my statement at the beginning, and that is everybody has got to go back to the drawing board and we do have to rethink what we have done and hopefully we could do so in as minimal a political context as possible, because these numbers ought to sober everyone up, and that we ought not to offer old panaceas to the very new and real problem, I think has even more import.

Mr. KLECZKA. Mr. Chairman, one quick question, if I might.

Chairman THOMAS. Sure.

Mr. KLECZKA. What was the extension under the Republican plan? We have 2001 current. The 124 takes us to the year 2005.

Chairman THOMAS. Under the old numbers, we believed we were solvent until 2010. Under the new numbers projected by CBO, we probably would not make the 2006 date either. It will be somewhere around a 7-year effort, I believe, and that, I guess, is partly what I tell my friend from Wisconsin is the problem that we are faced with.

Now not only does the trust fund go broke 1 year earlier, but the spend out after that is such that any of the proposals that were offered previously really don't make the kind of curve adjustments necessary to put us in the ballpark, and in addition to that, I believe Dr. Van de Water said that on the part B spending, we would require even larger changes to bring the SMI part B spending in line with growth of the economy.

Would you elaborate on that? What did you mean by that?

Mr. VAN DE WATER. As I indicated in my statement, SMI spending is growing in our projection and in those of the administration at even greater rates than spending on the Hospital Insurance Program. So, simply as a matter of arithmetic, bringing that rate of

growth down to comparable levels would require a larger proportional reduction.

In dollar terms, it wouldn't be as great because, for the moment, SMI is still a smaller program than HI, but it is growing more rapidly.

Chairman THOMAS. Do you have any dollar figure that you could place on what that adjustment would be in terms of needed part B savings?

Mr. VAN DE WATER. As were the examples in my prepared statement, this is just illustrative, but if one were to try reducing the present rate of growth, which is projected to be in excess of 10 percent down to about the rate of growth of GDP which is roughly 5 percent, the cumulative savings in SMI over 10 years would be approximately $330 billion.

Chairman THOMAS. Of course, the pressure on part A is precisely because it is a trust fund and it has dedicated dollars. Part B can tap into the general fund, and to the degree that we do not have a payment scheme for beneficiaries to pay whatever "their fair share" is, we tap even more heavily into the general fund.

I guess at this stage, I am not all that excited about talking about solutions to combine part A and part B if it means you have access to the general fund to "solve your problem." I think it is the growth rate of 9 percent-plus in the trust fund and 10 percent in part B that we have to focus on.

The other problem that I have very much with your testimony is the idea that we would even suggest that the payroll tax be a solution to the problem. The American people were the beneficiary of a 1993 removal of the lid on the payroll tax by President Clinton and the Democrats who were then controlling the majority of the Congress. It was the largest tax increase in history, and that basically has been washed away by the numbers.

No question, we would be in much worse shape had they not had this enormous tax increase, but to say that we are going to go to a 25-percent increase on the HI payroll tax is, in my opinion, totally and unfairly continuing the shift of an intergenerational transfer of funds that I think are unprecedented in the history of this country.

If I were to ask you if we went to a 25-percent increase on top of the current payment, how much would that be?

Mr. VAN DE WATER. The current payroll tax rate for Medicare is 1.45 percent each for employers and employees making a total of 2.9 percent. So a 25-percent increase would bring that to a total of roughly 3.7 percent.

I might add, if I might, Mr. Chairman, that CBO was not recommending a payroll tax increase, just as we were not recommending any particular benefit cuts. I was running through some purely illustrative examples to try and add some tangibility.

Chairman THOMAS. I understand that, but on an illustrative example, I also need a ready answer from you to the 30-year-old who then says, "Well, OK, so I am going to pay this for 35 years. So what are the odds on my getting something at the end of this process, having paid out at the highest rate in history?," and the answer is you are going to be able to work longer and you are going to have to stay alive longer to get anywhere near the return that

the current generation gets. That is my problem in terms of this intergenerational transfer.

The gentleman from California wants to interject.

Mr. STARK. This is to ask along the lines of the Chairman's inquiry.

You give as an example at the end of your testimony that we would either have to increase 0.7 percent, and I assume that is 35 basis points on both sides, or cut the rate of growth from 8 to 4.5 percent, which many of us think perhaps is not sustainable by the system.

Do you have a tradeoff there? What if we got back to the good old days of compromise and say, well, maybe we will do 0.3 percent, 15 basis points? How low would we have to drop the growth rate, or could you later supply to us some options in that raise? I think 4.5-percent growth rate is too far a cut, and I would agree with the Chairman. I think 0.7 percent would be politically unpalatable, but not to suggest that somewhere in the middle there might not be options that would be more attractive.

If you don't know what 10 basis points does in the growth rate off the top of your head, I don't have any idea whether those are linear or what.

Mr. VAN DE WATER. They are, indeed.

Mr. STARK. Are they?

Mr. VAN DE WATER. Given the hypothetical approach that we use, both of those alternatives——

Mr. STARK. So you could extrapolate it just linearly.

Mr. VAN DE WATER. Right.

Mr. STARK. OK. Thank you.

Mr. VAN DE WATER. In other words, if you wanted to do half and half, you would require a——

Mr. STARK. A 1.5-percent cut in the growth rate and about 35 basis points. OK.

Mr. VAN DE WATER. Exactly.

Mr. STARK. All right. That answers it. Thank you.

Chairman THOMAS. You can go ahead if you want to.

Mr. STARK. I guess that is what I wanted to point out.

I did want to suggest to you that earlier in your testimony you suggest that we have got to——

Chairman THOMAS. Just one point on that, though, just to finish the discussion. Notwithstanding the fact that the longer we project out this shared structure, the chances of the old-fashioned hospital remaining separated from the physician side of payment says that current Medicare part A/part B concept is going to be less relevant to the beneficiaries in terms of the way in which health care is delivered. So I think, at some point, we may need to engage about that choices discussion that we previously engaged in and that perhaps a combination of the two under a new structure rather than a combination of the two under the current structure might be an option as well.

I thank the gentleman.

Mr. STARK. In your growth rate discussion, in the President's proposal, we cut to about 6.5 percent, and I think the Republican proposal, I am going to guess, is about cutting to a growth rate of 5.7 percent. The private sector growth rate based on those same as-

sumptions was projected to be around 7 percent. I guess what troubles me, and this is what I would ask for your comment, if we had a substantially lower growth rate locked in for the public sector program below the private sector, wouldn't we basically either push us toward rationing or cost shifting? I don't know whether you are able to comment. It is my opinion that that is what it would lead to; that we have to keep our growth rate in the public sector pretty close to what the private sector growth rate will be or will cause those kinds of problems in the market.

Is that a fair assumption, or is there something unique about the delivery of medical care?

Mr. VAN DE WATER. I don't think that I am as well-positioned as your following witnesses to address that, but I think the gist of what you suggest is probably correct.

The problem from our point of view is that these comparisons between rates of growth in the private sector and the public sector are very difficult to do.

For example, the benefit packages of the two sectors may be changing. The Medicare benefit package in recent years has probably been either roughly constant or perhaps getting better. The typical benefit package in private employer-sponsored health insurance may have been moving in the other direction. So that is one difficulty in comparison.

The demographic compositions of those in the public and in the private program may have been changing in different ways.

There are also technical problems in comparing the data because private health insurance spending includes, for example, spending for people covered by Medigap plans, and you really want to think of them in the elderly rather than the nonelderly group.

In response to concerns and questions such as yours, we at CBO are undertaking an analysis that is trying to look at how one can do an honest job of comparing growth rates in the public and private sectors, and we hope to have that available in the early summer.

Mr. STARK. Could I just finish with the comparing, though, within Medicare by itself? PPRC indicates that when we have people joining a Medicare managed care plan, we are really losing money because it tends to be the younger, healthier Medicare beneficiary. So we are getting some cost shifting, if you will, within the Medicare system. They collect the same rate for the healthy, younger people, and it gets paid out in a capitated rate every month, and that costs us more than if we didn't pay anything on their behalf.

Is there something we can do? Have you thought of any way to balance that out to move toward managed care? How do we do that? Do we pay a lot less for younger, healthier people?

Mr. VAN DE WATER. I believe that Dr. Newhouse addresses that issue in his prepared statement, especially where he focuses on trying to develop ways of adjusting for differences in risk between people.

Mr. STARK. Has something wondrous happened in that area in the last couple of years? Is there a risk adjustment of protocol which you are willing to subscribe to at this point, and could you lend me a copy of your formula if that is it?

Mr. VAN DE WATER. I am not aware of it at this point.

Mr. STARK. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. It is becoming the holy grail.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you.

Thank you for your testimony, Dr. Van de Water.

I, too, would like, just for the record, to say that financial soundness is not an issue for the SMI Trust Fund is theoretically correct, and I understand it is theoretically correct, but in fact, it is incorrect. There is absolutely no way that taxes can go up at the rate they would have to go up, as you have well described for tax revenues to deal with the problem even in part B. It is true, as you point out in your testimony, that in part A, there is not even this safeguard.

I want to ask you a little bit about your testimony in regard to the growth in HMOs. You mentioned that it is the fastest growing component. Membership in HMOs is the most rapidly growing component.

In those States where Medicare Select has been on the market for 2 years, is their growth rate faster or slower in the managed care plans as opposed to the HMO risk contracts?

Mr. VAN DE WATER. I don't know the answer to that question.

Mrs. JOHNSON. Could you get back to me on that?

Mr. VAN DE WATER. Indeed.

[The following was subsequently received:]

MEDICARE SELECT

Medicare Select is a type of Medicare supplemental health insurance that pays in full for supplemental benefits only if they are delivered by preferred providers. The program began as a demonstration in 1992 and was originally limited to 15 states. The program was made permanent and extended to all states in 1995.

Medicare Select policies have been on the market for at least two years in 12 states: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Minnesota, Missouri, Ohio, Texas, and Wisconsin. From December 1993 to December 1995, 62 percent of the growth in enrollment in Medicare risk contracts took place in these 12 states, even though they are home to only 44 percent of Medicare enrollees. In the states with Medicare Select, enrollment in risk contracts grew from 1.4 million to 2.2 million over the period--an increase of 0.8 million or 57 percent. In the remaining states, enrollment in risk contracts grew from 0.4 million to 0.9 million--an increase of 0.5 million or 114 percent.

Mrs. JOHNSON. I think it is determinable.

Then, why in your estimates do you reduce your expected rate of growth in HMOs? You say that in 1996, it will be 25 percent, that is 25 percent of current enrollees, and current enrollees, as I recall, is only 9 percent. So 25 percent of 9 percent, you are expecting only a little over 2 percent growth.

Mr. VAN DE WATER. That is 2 percentage points.

Mrs. JOHNSON. Yes.

Does that take into account the availability of HMO risk contracts for seniors in parts of the country where they have not been available before, or is that estimate based on the rate of growth in those sectors of the market where there are currently HMO risk contracts?

Mr. VAN DE WATER. We certainly attempt to take account of what we think is going to happen in the future, not just look in the rearview mirror, but obviously, this is one of the many sources of uncertainty in the estimates.

Mrs. JOHNSON. I would be interested in getting into more detail with you on that at some other time.

Coming from a State that has not had much HMO or managed care activity until recently, I can tell you that the biggest fear of the hospitals and doctors is that by the time they get their networks up and running, the HMOs will have taken over.

I have never seen such a marketing operation. Nobody has ever seen such a marketing operation, but we now have a couple of HMO risk contracts that are all over every single senior citizen center. I can tell you, the difference in the way people are listening to them, the difference in the way they hear my conversation about the Republican proposal from 6 months ago and now is dramatic, and the number of seniors now, there is always in a seniors group now a few that have joined one of these programs and are doing very well, thank you, and so the word is spreading that you can get more benefits for the same or less cost.

The security that either a zero or a $5 or a $10 copayment gives retirees is simply enormous. They listen to that.

In the first year, from 1996 to 1997, you have it dropped from 25 to 20 percent. Then, by 1999, you project from 1999 to every year thereafter only a 10-percent growth.

Mr. VAN DE WATER. Could I clarify this?

Mrs. JOHNSON. By then, there will be a lot of plans in the market. They are offering far more benefits at far reduced cost, and I can't imagine when you look at the private sector's experience where you get that growth rate.

Mr. VAN DE WATER. Could I clarify this, Mrs. Johnson?

Mrs. JOHNSON. Yes.

Mr. VAN DE WATER. Perhaps my statement wasn't sufficiently clear on this.

Those figures may not be the clearest way, from your point of view, of looking at the increase in HMO enrollment. They simply reflect the fact that when you are starting out with a relatively small number, and as you say the current enrollment in risk plans is about 9 percent of the total, a given increase in HMO enrollment represents a relatively large percentage increase on the small base.

As more and more people join risk plans, that same absolute increase represents a smaller percentage increase per year.

Mrs. JOHNSON. I appreciate that.

Mr. VAN DE WATER. By 2002, for example, on our baseline, we project that enrollment in risk plans will be about 17 percent of the total.

Mrs. JOHNSON. In 10 years, you are going from 9 percent of the total to 17 percent. That is an 8-percent increase in 10 years. Frankly, you look at what happened in the private sector and I think you are not paying attention. We will get some other opinions on that, but the likelihood of going from 9 to 17 percent in 10 years strikes me as unlikely. I think it will be far greater than that. I think you are completely underestimating the seniors' interest.

Seniors are dying under the cost of their Medicare premium, figuratively speaking, perhaps literally, and the cost of Medigap insurance. Medigap insurance is beginning to outpace a senior's ability to buy it.

As that happens, their interest in zero premium HMOs that provide the benefits of a managed care plan or a Medigap policy is going to be extraordinary, and I don't think you are looking at that.

When I talk to seniors and hear what they are paying in Medigap premiums, they cannot keep doing it, and this year, those premiums went up in Connecticut.

Mr. ENSIGN. Would the gentlelady yield?

Mrs. JOHNSON. That makes the HMO option far more desirable.

So I would just like to help you look at your growth rates and what you think is going to happen in this because I think you are really significantly off.

Yes, I would be happy to yield.

Mr. ENSIGN. Real quickly, just one comment in my area, we for several years have only had two HMOs provided for Medicare recipients. We have 30 percent of our population now that is covered in the senior population.

Mrs. JOHNSON. And 2 years ago, you had one HMO risk option in the Boston market. Now you have four, and they are all zero premiums, with the exception of Harvard which has gone down from $85 to $15, but the rapidity of change doesn't seem to be reflected in your numbers. I understand your numbers are honest. They are based on your assumptions, but I certainly would like to begin to spend some time with you on what your assumptions are because it doesn't check with my experience, and particularly this issue of the rising cost of Medigap insurance driving people to look for alternatives.

Thanks.

Chairman THOMAS. The gentlewoman's time has expired.

Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

I thank you for your testimony. If there was ever an issue where I thought the American people could come together on and the Members of Congress and the administration could come together on and work together in a bipartisan fashion, it would be solving this whole challenge that we have before us.

I look at the numbers in your testimony. Many of us have conducted townhall meetings and forums, and we have heard, but, oh,

there is $122 billion in the reserve, it is going to be there, we are not really facing any problem. I see, this year, you are projecting $7 billion loss, next year $13 billion, 1998 $22 billion loss, $30 billion, $38 billion, $48 billion, $57 billion, $68 billion, $82 billion in year 2005, and $96 billion deficit. It is amazing that we can't come to some kind of agreement on this and get this solved.

Even our program wasn't based before these projections came out. It would not get us as far as we needed to get to saving the program.

So I guess my question is, back when you were looking at modifying the projections for this past year, what were some of the parameters that you used in modifying your projections?

Following up on Nancy Johnson's comment, did you look and examine what was going on in some of the markets that are using the HMOs, such as Arizona, in modifying your projections and your results?

Mr. VAN DE WATER. As you probably noticed in looking at these numbers as carefully as you have, the changes on both the outlay and the revenue side of our projections are really fairly modest on a year-by-year basis, but when you add them all up over 10 years, when you accumulate them to find out what the effect on the accumulated deficit or surplus is, they turn out to be rather large.

There is no single earth-shaking fact that one can point to that accounts for the change in projections. On the income side, we have just slightly lower receipts reflecting two things: First, the projection of slightly less rapid growth in the wage and salary base on which payroll taxes are levied, and second, an even smaller reassessment on the part of the Social Security Administration with regard to the portion of wages and salaries which would be subject to the payroll tax.

On the outgo side, we have changed the rate of growth in hospital insurance very little. Most of the change simply reflects the fact that spending in the current year is running a bit higher than we had thought a year ago at this time, and if you just project out a small difference, it comes close to tripling over the 10-year period that we are showing.

So there is no smoking gun, so to speak, that one can point to that accounts for these changes. They are really very modest, but on balance, they do shorten the life of the fund by a year and add roughly $100 billion to the accumulated deficit over 10 years.

Mr. CHRISTENSEN. Mr. Chairman, as a freshman on this Committee and as someone who has been targeted by the AFL–CIO and an opponent who is the recipient of hundreds of thousands of big labor dollars focused on the issue of "cutting" Medicare because we supposedly don't care about our seniors, I am outraged by those who are defenders of the status quo that would allow this system to go bankrupt.

To hear people even contemplating the thought of raising taxes really should be an outrage to the American people because even raising taxes won't fix this problem. Until this Congress has the will to do what is necessary, to change the entire program, it is not going to get done.

If we can't come together in a bipartisan fashion to achieve the results that are needed to save this system, so that we don't have

the intergenerational transfer that is going on today, I pity where this program goes, and it is shameful that we have defenders of the status quo that will play politics with this issue with the Republican majority.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. A bipartisan solution might be doable if all parties had input into the solution, but for one side to do it and to try to ram it down the other side is not compromise and is not bipartisan.

Mr. CHRISTENSEN. Would the gentleman yield for a moment?

Mr. KLECZKA. Dr. Van de Water, the question I have is, you indicated that the rate of growth in HI for 1996, even though it is exceeding the projection by $7 billion, is still modest? Was that your terminology?

Mr. VAN DE WATER. The modest differences in outlays and revenues separately produce relatively large differences in the annual surplus or deficit and the accumulated trust fund balance.

Mr. KLECZKA. In your review of the expenditures from this particular account, have you been able to decipher what the actual factors were? Is it totally utilization, or what might we be seeing here?

Mr. VAN DE WATER. As I indicated in my statement, the detailed data on the composition of Medicare spending with respect to type of service or category of beneficiary only become available with a very great lag. So, in fact, at this time, all we know is total Medicare spending.

Mr. KLECZKA. You don't have any guesstimate on historical trends or trends from 1995?

The entire statement has a lot of data on things that have occurred and will occur up to 2006. I wonder if you just can't pinpoint something going on there that we should be aware of as we talk about it today.

Mr. VAN DE WATER. These things change unexpectedly, and in ways that even the experts have a great deal of trouble explaining.

Again, referring to Dr. Newhouse's statement, I was struck by the chart that compares sources of growth in Medicare over recent time periods. In the most recent time period, if I am remembering his chart correctly, we have a substantial increase in utilization on the part of Medicare beneficiaries. In the preceding time period, there was very little growth in utilization, but a very large increase caused by the so-called residual factor, which is the analyst's word for everything that we don't understand.

I don't think there is a clear understanding of what the residual is or why it is so large in some time periods and so small in others.

Mr. KLECZKA. Thank you very much.

Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. Chairman, may I?

Chairman THOMAS. Certainly.

Mr. CHRISTENSEN. Mr. Kleczka, I would be more than happy to work with you in a bipartisan fashion. You have always been good about your openness, and this issue is a bipartisan issue that we could work together on, but when people in your party have used this as a political tool to target a number of freshmen, it makes one

less inclined to work together, but maybe we can work together outside of this room.

Chairman THOMAS. As the Chair stated in his opening remarks, even the Washington Post has indicated that there was a degree of medigoguery being carried out by the President, but the point I tried to make was that the numbers ought to be sobering enough. If we refer to Dr. Newhouse's charts, which we will get to shortly, I guess the thing that ought to drive us together to move toward a solution as soon as possible is that the CBO numbers prove that it can get worse.

This is not, I don't think by any means, the bottom end of the scenario based upon the various factors, and that is one of the things we have to get at.

I believe the gentlewoman from Connecticut wanted to clarify.

Mrs. JOHNSON. Thank you very much. I do want to just clarify.

You gave us some information about what you thought would be the impact of the President's proposal to reduce Medicare spending by $124 billion over 7 years, and you said that instead of extending the life of the program 10 years that it would add 4 years to the life of the program.

Of the present savings, how much of the savings comes from part A and how much from part B?

Mr. VAN DE WATER. In our estimation, the total Medicare savings over 7 years in the President's latest submission are $116 billion.

The part A savings are, in fact, $128 billion; that is, the part A savings exceed the total savings because of the shift of some of the home health spending from part A to part B that the Chairman referred to.

Mrs. JOHNSON. How much of that $128 billion is due to the shift?

Mr. VAN DE WATER. In that 7-year period, the number is $55 billion. I had incorrectly indicated earlier that it was $37 billion, but the correct number is $55 billion.

Mrs. JOHNSON. So $55 billion of the $128 billion is "saved" in part A because it shifted to part B, correct?

Mr. VAN DE WATER. Yes.

Mrs. JOHNSON. So it is not a real savings. It is not like cutting reimbursement rates and, therefore, the money isn't going out the door. It is going out the door, just from a different fund, correct?

Mr. VAN DE WATER. Correct.

Mrs. JOHNSON. So there is no savings in part B. In fact, there is an increase in cost in part B of $55 billion?

Mr. VAN DE WATER. Yes. It is simply a shift.

Mrs. JOHNSON. That increase in cost of $55 billion, what would be the premium increase necessary in part B, to just cover the percent of that new cost that is parallel to the percent of cost that the current part B premium is carrying? When I say current part B, I don't mean the current part B in current law, whatever is in the President's proposal? In other words, he lowers the part B premiums, but he pegs them at dollar amounts, and those dollar amounts cover a certain percent of part B spending.

If you were to require seniors to carry that same percent of the new home care expenditures, what would be their increase in premium costs? I would like to know the same figure. You may not

have those now. If we did this through the tax structure, what would be the increase in taxes that would have to be levied, Medicare taxes, if we were to cover this $55 billion cost through increasing Medicare taxes?

Mr. VAN DE WATER. The President proposes, as you know, to set the SMI premium so as to cover 25 percent of program costs. Under that assumption, the premium that would attach to part B spending is 25 percent of $55 billion.

Mrs. JOHNSON. So under his program is 25 percent of program cost, but because he is shifting new cost into part B, his premiums actually would go up?

Mr. VAN DE WATER. No, because the President also specifies that these particular additions to part B spending would not be counted for purposes of determining the premium.

Mrs. JOHNSON. So they will be paid for entirely through the tax income, the tax dollars that flow in?

Mr. VAN DE WATER. Yes.

Mrs. JOHNSON. Would you get back to me later on as to what kind of increase they would trigger if they were counted as part of the 25 percent?

Mr. VAN DE WATER. That was the earlier answer I gave you. If they were counted, it would lead to a premium increase of 25 percent of $55 billion, roughly $13 billion.

Mrs. JOHNSON. Oh, I see. I didn't understand that.

Then, if you could get back to me about how that would work out in terms of payroll tax, I would be interested in that.

Mr. VAN DE WATER. What payroll tax rate it would take to finance?

Mrs. JOHNSON. Right. What kind of payroll tax increase it would take to fund those, the home care expenses, so that we would not have a new tax through other avenues. I just want to know for a matter of fact. I think the problem with $124 billion is not only that it only adds 4 years instead of 10, but also that it is a sleight of hand, and I am appalled that the $55 billion was not allowed to have any weight in the premium and it is totally a generational tax shift.

Thank you.

Mr. VAN DE WATER. Mrs. Johnson, I could actually give you an indication of that answer right now. The 0.7-percent increase in the payroll tax, which I used in my hypothetical example, generated about $200 billion over 7 years. So, to raise about a quarter of that amount, the required increase would be about a quarter of 0.7, or close to 0.2 percent on the payroll tax.

Mrs. JOHNSON. Thank you. I appreciate that.

Mr. STARK. Mr. Chairman.

Chairman THOMAS. The gentleman from Nevada was going to try to get in on it first, but is this followup of that?

Mr. STARK. It is a followup. I just wanted to stipulate that I am sure that in our bill there has been sleight of hand, but I think I am also correct that in the Republican bill, the part B premium increase was transferred into part A for several billions of dollars, and the GME Trust Fund was taken out and an appropriated trust fund was created. So that, in both bills, we used transfers from one trust fund to the other. While one may be better than the other,

I didn't want the record to suggest that the Democratic bill was the only one that transferred money in or out of trust funds. Both bills did it, and indeed, we could have a discussion as to which is a better way to do it, but it is in both bills.

Chairman THOMAS. I want to tell the gentleman that we transferred savings. Your bill transferred costs, and that is a final retort, I think, that we ought to offer here because we were not the ones who offered the old program as a continuing solution to the new problem.

I tried in my opening statement to point out all of us had better sober up and look at these new numbers in light of the CBO report. It was the gentleman from California's opening statement that reoffered the President's $124 billion, which led to the analysis of the inadequacy of that plan. I never offered our plan as the solution to the current problem. We thought it met the old problem. I am sobered by the fact that you talked about it being so extreme. It may not cover the numbers that we are now dealing with.

We have a real problem, and I have asked the President to step forward in the mode of nonpolitical leadership to address this problem. For us to lob political grenades back and forth over our old plans doesn't advance this one whit, in my opinion, toward solving this increased problem.

Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I apologize if I am repeating simply because I wasn't here earlier.

Just in general terms, because of the political situation that we are in on Capitol Hill with the Presidential election year, I have two questions. One is, let us just say that we are not able to come to an agreement with the President this year and we have to wait until next year. How much more severe do the changes have to be each year you put this off?

In other words, we may not come to an agreement this year, but there is no guarantee there would be agreement next year. There is no guarantee there would be agreement the year after that or the year after that. The bottom line is, what happens if we get to the year 2001 and we are bankrupt? What are our options at that point?

Mr. VAN DE WATER. If you did not take any steps before that date, you would be left with much more draconian solutions, namely, even sharper reductions in benefits or—dare I say it—greater increases in payroll taxes than what you would have had, had you started to take steps earlier.

Alternatively, if those increases are so large as to seem politically unpalatable, which might well be the case, one could well imagine that there would be pressures for general revenue financing or some other approach that would avoid those tough choices.

Mr. ENSIGN. It sounds like to me that if we don't have the courage to make the tough political votes today, the solutions that are available to us are not solutions that would be available to us, simply because, politically, solutions have to be political as well as meeting within the systems that you have, and while the politics of today are very difficult, as they were last year, it still seems to me that they are easier this year than they will be 3 years from now or 4 years from now or 5 years from now.

I think that is, as a matter of fact, what Chairman Thomas is talking about. The longer that we wait, the more we let politics get in the way of saving Medicare, the more difficult that it will be to save Medicare, if not impossible.

Mr. VAN DE WATER. If you start now, you can deal with the problem simply through slowing the rate of growth in the program. If you actually waited until 2001, however, then you are faced with the choice of reducing the absolute level of spending below what it was in the previous year, which is clearly quite a different matter.

Mr. ENSIGN. Just real briefly, in science there is something known as error bars, and I know yours is not an exact science, but, percentagewise, what are your errors bars on your estimates on, say, the amount of the trust fund? It is now, what, $332 billion in deficit in 2005? Is that the projection?

Mr. VAN DE WATER. That is the projection.

Mr. ENSIGN. What would be your error bars on that, plus or minus what percent?

Mr. VAN DE WATER. We don't know enough to have a statistical model that would allow us to develop error bars in any sophisticated way, but you can see simply by the fact that that number has changed by $100 billion over the past 13 months that the error bar is extremely large. As Mr. Thomas said, we hope that we are not going to be bringing still more bad news of this sort next year at this time, but if it has happened once, it could happen again.

Alternatively, if the rate of growth of spending were to slow even slightly, as some people project, we could come back next year and say that it looks as if we had a bit of a false alarm. But the error bars are extremely large when you are talking about projections 10 years away.

Mr. CHRISTENSEN. Would the gentleman yield?

Mr. ENSIGN. Certainly.

Mr. CHRISTENSEN. In 1965, when the program was started, the CBO or some actuary projected that in 1992, it would cost $9 billion. The error bars were a little off because it cost $175 billion. I hope your error bars are better than your 1965 predecessor's.

Mr. VAN DE WATER. That is one of those statements that is easily disproved because CBO wasn't created until 1974.

Mr. CHRISTENSEN. Whatever.

Mr. VAN DE WATER. I believe you are referring to the actuary's projections, but we face the same issues that they do. I should say on their behalf that a lot of the change has to do with the differences in the projected rates of inflation because, in the midsixties, the rapid rates of inflation during the following 15 years were not expected.

Mr. CHRISTENSEN. Hopefully, you are closer.

Mr. VAN DE WATER. You are absolutely right. That is an illustration of how far things can go awry.

Mr. ENSIGN. Just real briefly on my remaining time, on these projections and the closer that we get to the destruction day of Medicare, just briefly your comments. You have been around here for a while. Do you think that we can sit down in this type of a political atmosphere? I am asking you not as a statistician now, but more as somebody who is an observer of the process.

Mr. VAN DE WATER. That is probably a question I shouldn't even attempt to answer, but I will cite an example.

You will remember that in the early eighties, this same situation that is now looming in the Hospital Insurance Trust Fund was facing the Old-Age and Survivors Insurance Program. The Social Security Program itself was projected to run out of money. D-day was looming within just a few months.

Ultimately, the so-called Greenspan commission was appointed, and that group was able to work with both sides of the Congress to work out a solution that was put into place. Now, of course, the Social Security Trust Fund is projected to be solvent not for 75 years, but well beyond the projected date of insolvency of the Hospital Insurance Program. So I think that that experience does provide a model of the kind of solution that could be worked out.

Mr. ENSIGN. I hope you are right.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

Paul, I would only say that if you come back in a few months and say that it is a false alarm, what you really mean to say is that the indicators that you assumed were going to continue have changed, and as a matter of fact, that would be the final request.

If you can, to the best of your ability, break out for us what you think the cost factors are. For example, I know that the number of new beneficiaries is a fairly constant number. The hospital admissions is the one that is puzzling us; not the fact that it has gone up, that is a fact. Why is the thing that concerns us. If we are going to try to work together on a bipartisan basis, we need to know what it is we are working on.

So, to the best of your ability, if there are macroeconomic indicators that have shifted as well, at least we would like to know that. So, if you would, to the best of your ability, give that to us, I would love to have them weighted in terms of the most significant to the least significant shift that has occurred between last year and this year. That would give us an indication of where the gremlins are.

Mr. VAN DE WATER. Yes, Mr. Chairman.

[The following was subsequently received:]

CBO April 1996 Baseline: MEDICARE

17-Apr

Outlays by fiscal year, in billions of dollars

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
PART A: HOSPITAL INSURANCE (HI)												
TOTAL HI OUTLAYS /1	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
Annual Growth Rate		10.7%	9.5%	9.0%	8.2%	7.8%	7.6%	7.4%	7.5%	7.7%	7.7%	7.9%
TOTAL HI MANDATORY /2	113.6	126.0	138.0	150.5	162.9	175.6	189.0	203.0	218.2	235.0	253.2	273.4
TOTAL HI BENEFITS /3	113.4	125.7	137.8	150.2	162.6	175.3	188.7	202.6	217.8	234.6	252.9	273.0
Annual Growth Rate		10.8%	9.6%	9.1%	8.2%	7.8%	7.6%	7.4%	7.5%	7.7%	7.8%	8.0%
Hospitals	79.8	84.1	88.5	93.7	99.2	104.7	110.1	115.3	120.8	126.6	132.5	138.6
Annual Growth Rate		5.4%	5.2%	5.9%	6.0%	5.5%	5.2%	4.7%	4.7%	4.8%	4.7%	4.7%
HMOs	7.7	10.5	13.6	16.9	19.9	23.3	27.3	31.9	37.3	43.6	51.0	59.7
Annual Growth Rate		36.5%	29.9%	24.0%	17.7%	17.2%	17.0%	16.8%	16.9%	17.0%	17.1%	17.0%
Hospice	1.9	2.5	3.1	3.7	4.2	4.7	5.2	5.7	6.2	6.7	7.3	7.9
Annual Growth Rate		32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%	8.5%	8.5%	8.5%	8.5%
Home Health	14.9	17.5	20.1	22.5	24.6	26.7	28.9	31.3	33.8	36.5	39.4	42.4
Annual Growth Rate		17.7%	15.0%	11.7%	9.3%	8.6%	8.4%	8.2%	8.1%	8.0%	7.8%	7.8%
Skilled Nursing Facilities	9.1	11.0	12.4	13.6	14.7	16.0	17.3	18.6	20.0	21.4	22.9	24.6
Annual Growth Rate		20.6%	12.9%	9.3%	8.5%	8.4%	8.1%	7.7%	7.4%	7.3%	7.1%	7.1%
PART B: SUPPLEMENTARY MEDICAL INSURANCE (SMI)												
TOTAL SMI OUTLAYS /1	65.2	71.9	79.3	87.8	96.5	106.0	116.4	127.9	141.3	156.5	173.4	192.4
Annual Growth Rate		10.2%	10.4%	10.7%	9.9%	9.8%	9.8%	9.9%	10.5%	10.8%	10.9%	10.9%
TOTAL SMI BENEFITS /3	63.5	70.1	77.5	85.9	94.5	103.9	114.2	125.6	138.8	153.9	170.8	189.6
Annual Growth Rate		10.4%	10.5%	10.9%	10.0%	9.9%	9.9%	10.0%	10.6%	10.9%	11.0%	11.0%
Benefits paid by Carriers /4	41.7	44.6	47.6	51.3	54.8	58.3	61.9	65.6	69.9	74.8	80.1	85.7
Annual Growth Rate		6.9%	6.9%	7.6%	6.8%	6.4%	6.2%	5.9%	6.6%	7.0%	7.1%	7.1%
Physician Fee Schedule	33.0	35.1	37.0	39.3	41.3	43.1	44.8	46.3	48.3	50.7	53.4	56.2
Annual Growth Rate		6.2%	5.6%	6.2%	5.0%	4.4%	4.0%	3.4%	4.3%	5.0%	5.2%	5.3%
Benefits paid by Intermediaries /5	15.4	17.3	19.4	21.9	24.6	27.7	31.2	35.0	39.1	43.4	47.9	52.7
Annual Growth Rate		12.5%	12.4%	12.4%	12.7%	12.6%	12.4%	12.2%	11.7%	11.1%	10.4%	9.9%
Group Plans	6.4	8.2	10.4	12.8	15.2	17.9	21.2	25.1	30.0	35.9	42.9	51.4
Annual Growth Rate		28.0%	26.6%	23.0%	18.6%	18.1%	18.3%	18.5%	19.4%	19.6%	19.7%	19.6%

1/ Includes discretionary administration.
2/ Includes mandatory administration.
3/ Includes the impact of PL 104-121, enacted on March 29, 1996. This impact is not distributed to the components of Medicare benefits.
4/ Includes all services paid under the physician fee schedule, durable medical equipment, independent and physician in-office lab services, ambulance services paid by carriers, and other services.
5/ Includes outpatient hospital services, lab. services in hospital outpatient departments, hospital-provided ambulance services and other services.

CBO April 1996 Baseline: MEDICARE

26-Apr

Outlays by fiscal year, in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Part A Information:												
HI Trust Fund Income	114.8	119.9	126.0	129.7	134.3	138.8	142.8	147.3	151.4	155.1	159.2	163.0
HI Trust Fund Outlays	114.9	127.1	139.3	151.8	164.2	177.0	190.4	204.5	219.7	236.6	255.0	275.2
HI Trust Fund Surplus	-0.0	-7.2	-13.3	-22.1	-30.0	-38.2	-47.6	-57.1	-68.3	-81.5	-95.8	-112.2
HI Trust Fund Balance (end of year)	129.5	122.3	109.0	86.9	56.9	18.7	-28.9	-86.0	-154.3	-235.8	-331.6	-443.8
Part A FY Enrollment (in millions)	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
HI Deductible (calendar year, in dollars)	$716	$736	$764	$796	$832	$868	$904	$940	$980	$1,020	$1,064	$1,108
Monthly Premium (calendar year, in dollars)	$261	$289	$311	$334	$356	$378	$402	$426	$451	$480	$510	$538
Premiums collected	$1.0	$1.1	$1.2	$1.4	$1.5	$1.6	$1.7	$1.9	$2.0	$2.2	$2.4	$2.6
PPS Market Basket Increase	3.6%	3.5%	3.3%	3.5%	3.5%	3.4%	3.4%	3.3%	3.4%	3.4%	3.4%	3.4%
PPS Update Factor (average)	1.9%	1.5%	2.8%	3.5%	3.5%	3.4%	3.4%	3.3%	3.4%	3.4%	3.4%	3.4%
Part A Hospital Inpatient Payments:												
PPS Hospitals	69.2	72.6	75.5	78.7	82.3	86.0	89.5	92.9	96.3	99.9	103.4	107.2
Non-PPS Hospitals/Units	10.6	11.5	13.0	14.9	16.9	18.6	20.6	22.4	24.4	26.7	29.0	31.5
Disproportionate Share Payments	3.9	4.6	4.8	5.0	5.2	5.4	5.6	5.8	6.0	6.3	6.5	6.7
Indirect Medical Ed. Payments (for patient care)	4.9	5.2	5.5	5.8	6.3	6.7	7.2	7.7	8.2	8.8	9.3	9.9
Inpatient Capital Payments	7.9	9.6	10.4	11.1	11.8	12.6	13.0	13.3	13.7	14.1	14.4	14.8
Part A and Part B Hospital Inpatient Payments:												
Direct Medical Ed. Payments (for teaching program	2.3	2.4	2.5	2.6	2.7	2.9	3.0	3.1	3.3	3.4	3.6	3.7
Part B Information: (in calendar years, except as noted)												
Deductible (in dollars)	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100
MEI percentage change	2.1%	2.0%	2.2%	2.1%	2.0%	2.0%	1.8%	1.8%	1.9%	1.8%	1.7%	1.7%
Physician Update (weighted average)	7.4%	0.4%	1.2%	0.0%	-3.0%	-2.6%	-3.2%	-2.9%	-0.6%	0.0%	1.2%	1.7%
Conversion Factor	$36.11	$36.28	$36.75	$36.74	$35.65	$34.75	$33.66	$32.68	$32.49	$32.51	$32.91	$33.50
Primary Care Update	7.9%	-2.7%	2.5%	7.2%	-3.0%	-1.0%	-3.2%	-3.2%	-0.5%	-0.5%	1.5%	2.5%
Conversion Factor	$36.38	$35.42	$36.31	$38.93	$37.77	$37.40	$36.22	$35.08	$34.89	$34.71	$35.24	$36.13
Surgical Update	12.2%	3.4%	2.2%	-2.9%	-3.0%	-3.0%	-3.2%	-3.1%	-0.6%	0.7%	1.7%	2.2%
Surgery Conversion Factor	$39.45	$40.80	$41.68	$40.48	$39.27	$38.07	$36.87	$35.73	$35.52	$35.76	$36.37	$37.15
Anesthesia Conversion Factor	$14.77	$15.28	$15.61	$15.16	$14.71	$14.26	$13.81	$13.38	$13.31	$13.39	$13.62	$13.92
Other Physician Update	5.2%	0.0%	0.3%	-1.3%	-3.0%	-3.0%	-3.2%	-2.7%	-0.6%	-0.0%	0.9%	1.2%
Conversion Factor	$34.62	$34.63	$34.74	$34.30	$33.28	$32.26	$31.24	$30.39	$30.21	$30.21	$30.47	$30.84
Laboratory Update	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
DME Update	3.2%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
P+O Update	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
ASC Update	0.0%	2.9%	3.1%	3.0%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%
Monthly Premium (in dollars)	$46.10	$42.50	$44.40	$48.70	$50.20	$51.70	$53.20	$54.70	$56.30	$58.00	$59.70	$61.50
SMI Premium Receipts (fiscal years, in billions) /1	19.2	18.8	19.4	21.2	22.5	23.5	24.5	25.5	26.6	27.8	28.7	29.5
Fiscal Year Enrollment (in millions)	35.5	36.0	36.5	36.9	37.3	37.7	38.2	38.6	39.0	39.5	40.0	40.6

1/ Includes the impact of PL 104-121, enacted on March 29, 1996.

CBO April 1996 Baseline: MEDICARE

17-Apr

Outlays by fiscal year, in billions of dollars.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
RISK HMO SPENDING AND ENROLLMENT												
Part A Risk HMO Outlays (FY)	7.7	10.5	13.6	16.9	19.9	23.3	27.3	31.9	37.3	43.6	51.0	59.7
Part B Risk HMO Outlays (FY)	5.4	7.3	9.5	11.9	14.3	17.1	20.4	24.3	29.2	35.1	42.2	50.7
Total	13.1	17.8	23.2	28.8	34.2	40.4	47.7	56.2	66.5	78.7	93.2	110.3
Part A Risk HMO Outlays (CY)	8.4	11.3	14.5	17.7	20.8	24.3	28.4	33.2	38.8	45.4	53.2	62.2
Part B Risk HMO Outlays (CY)	5.9	7.8	10.1	12.5	14.9	17.8	21.3	25.4	30.5	36.7	44.1	52.9
Total	14.3	19.1	24.6	30.2	35.7	42.1	49.7	58.6	69.4	82.1	97.3	115.1
Part A Enrollment (FY)	36.9	37.5	38.1	38.6	39.1	39.5	40.0	40.6	41.1	41.7	42.3	43.0
Part A Enrollment (CY)	37.1	37.7	38.2	38.7	39.2	39.7	40.2	40.7	41.2	41.8	42.4	43.1
FY Risk HMO enrollment March '96 baseline	2.7	3.4	4.1	4.7	5.1	5.7	6.2	6.8	7.5	8.3	9.1	10.0
Year to Year Change		25.0%	20.0%	15.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
CY Risk HMO enrollment	2.9	3.6	4.2	4.8	5.3	5.8	6.4	7.0	7.7	8.5	9.3	10.3
Year to Year Change		23.6%	18.6%	13.6%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Memo: FY HMO penetration rate /1	7.3%	9.0%	10.7%	12.1%	13.2%	14.3%	15.5%	16.9%	18.3%	19.9%	21.6%	23.3%
Memo: CY HMO penetration rate /1	7.8%	9.4%	11.0%	12.4%	13.4%	14.6%	15.9%	17.2%	18.7%	20.3%	22.0%	23.8%

1/ Risk HMO enrollment as a percent of Part A enrollment

Chairman THOMAS. Thank you very much.

It is now my pleasure to ask the new Chairman of the Prospective Payment Assessment Commission, Dr. Joseph P. Newhouse, accompanied by a familiar face, Dr. Don Young.

This is, I guess, the second Chairman of ProPAC. The first Chairman, Dr. Stuart Altman, was Chairman for 13 years, but he is back at Brandeis University. We certainly are grateful for the 13 years of Dr. Altman's service.

I would tell you, Dr. Newhouse, I hope that doesn't mean that you are being condemned to a 13-year sentence. Hopefully, we will get some good years out of you.

As the Republican Chairman of the Subcommittee, I have to indicate that notwithstanding the educational background of Dr. Newhouse, both undergraduate and graduate work at Harvard, he does partially redeem himself by two decades in Santa Monica at the Rand Institute.

It is a pleasure to have you with us. Your written testimony will be made a part of the record. It is extensive. There are a number of excellent charts that are associated with it, as alluded to by Dr. Van de Water, and you may inform us in any way you see fit. If you feel it is appropriate to refer to a chart, I think it is worth the time of the Members to turn to that chart and begin to look at it.

Joining us at the table is Dr. Gail Wilensky of the Physician Payment Review Commission. If you will allow me, Dr. Wilensky, although it is probably more comfortable there, I would like to get through ProPAC, and then we would turn to PPRC, notwithstanding some of the similarities in the testimony.

Dr. Newhouse.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DON YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. NEWHOUSE. Thank you very much, Mr. Chairman. I am very pleased to be here in my maiden voyage. I am accompanied by Dr. Donald Young, the Executive Director.

On March 1, the Commission submitted to the Congress its eleventh annual report containing recommendations for improvements to the Medicare Program. I am going to comment briefly on certain of these recommendations today, and I should say, however, that they were developed by the Commission before I became Chairman.

The Commission supports the efforts of this Committee to rein in the growth of Medicare spending. ProPAC believes spending for medical services in a private sector with market forces that encourage cost containment and high quality care provides a benchmark for the Medicare Program.

Judgments regarding the appropriate spending levels and rate of increase, however, should be based on several years experience to account for short-term factors that may give a misleading picture of the overall trends.

Indeed, the ability to compare and forecast Medicare and private sector spending is a complicated task, with a lot of data limitations. We are continuing to examine the available data and will present

more on this issue in our June report to Congress, "Medicare and the American Health Care System."

The changes that are occurring in the private sector financing of care are having a substantial effect on the way hospitals and other providers operate. ProPAC has been following closely the factors contributing to the growth of total hospital expenses, and we depict some of those in chart 2 which Dr. Van de Water also referred to.

Two of the factors shown there, general inflation and population growth, of course, are outside a hospital's control. They do have some control over real input prices, and they have some control over utilization of services, that is, the number of admissions and outpatient visits.

Between 1985 and 1992, over half of the cost growth was due to increases in the intensity of services furnished to inpatients and outpatients. That is over in the far right end of the chart. During this time, changes in hospital utilization, that is, admissions and outpatient visits, had little effect on total cost growth. However, after 1992, up through 1995, there is a dramatic change in this picture. The number of hospital outpatient visits continued to grow and admission rates began to climb, as you noted.

The most striking finding, however, is on the right. It is the virtual absence of any increase in the intensity of services to those people who were admitted. Consequently, total spending rose due to general inflation and increases in the number of people receiving care, but as I am going to come to momentarily, the growth in the cost to provide services to each patient slowed dramatically.

We believe that this slowing in cost, overall cost, is a response to the recent financial pressure from private payers, and in addition, much of the increase in utilization is due to an acceleration in admission rates for Medicare beneficiaries rather than private patients.

Let me turn to the capitation program. ProPAC strongly supports your efforts, Mr. Chairman, to control spending by reforming the Medicare capitation program and expanding beneficiary choice.

A major flaw in the current risk contracting program is the wide variability and volatility in payment rates across the country, which are shown in chart 4. Those are deciles of the AAPCC across all counties in the country.

In many areas the lower rates may discourage plan participation. The Commission supports your intent to reduce this variability. We are concerned, however, that even with the modifications you proposed, the rates may not accurately reflect appropriate cost of care in many areas. We believe over time the rates should better reflect the evolution of market forces that are occurring in each area.

There is another problem with Medicare's capitation program that you are aware of. Indeed, it has already come up today, and it must be resolved if the program is to succeed, and that is the lack of adequate risk adjustment methods to modify capitation payments. Effective risk adjustment is necessary to prevent unwarranted financial rewards and penalties to plans and incentives to avoid Medicare enrollees with chronic illnesses.

As you have said, the knowledge base in this area continues to be limited. We believe the Secretary should use available information to make modest improvements while vigorously supporting

further research. Other approaches to limit risk selection are also necessary, such as the improvements in enrollment and disenrollment policies you proposed.

I see the yellow light is on.

Chairman THOMAS. I will tell the gentleman that you are in Washington, DC, and no one pays attention to the yellow light or the red light.

Mr. NEWHOUSE. I see. I thought it was only in Boston that people don't pay attention to the traffic lights.

Chairman THOMAS. Don't pay any attention to it, and you will feel very comfortable here in the District.

Mr. NEWHOUSE. Thank you, sir.

When ProPAC appeared before you in September 1995, we noted the dramatic decline in hospital cost growth which began in the early nineties. That trend of lower cost growth continues.

If you look at chart 6, from 1984, the first year of PPS through 1990, Medicare PPS operating cost per discharge increased at an annual rate of 9 percent. Since then, it has moderated substantially and actually turned negative in the eleventh year of prospective payment, and as a result of that, margins have increased, as shown on the next chart, chart 7.

The Commission considered the decline in hospital cost growth as it developed its recommendation for fiscal year 1997 on the amount of the update. The framework that the Commission has used over time supports an update of about market basket minus 1.5 percentage points in fiscal year 1997.

In light of the significant changes occurring in health care delivery, including the recent gains in hospital productivity, it may be possible to hold PPS payment rate increases to an even lower level for the next few years, but we are concerned about the ability of hospitals to continue to provide high quality care if updates are constrained at this level through 2002.

It is unclear how long hospitals are going to be able to maintain the large productivity improvements we have seen in recent years. ProPAC plans to monitor these trends closely, and we will keep you informed.

I think I will skip over my comments on teaching and disproportionate share hospitals.

I will note, as you have already noted, that post-acute care has been an area of extremely rapid growth. We support your efforts there to control spending by moving to prospective systems that are at the episode level.

Outpatient hospital services have also grown substantially, and we support a prospective payment system that is consistent across all payers with volume control methods. We believe also that the growing financial burden on enrollees who receive services in hospital outpatient departments should be alleviated, should be limited to 20 percent of the Medicare-allowed payment, as in other settings, and are proposing to finance that, in part, by correcting flaws in the hospital outpatient payment formula.

That summarizes my formal statement, Mr. Chairman, and I will be pleased to answer questions, as you would like.

[The prepared statement and attachments follow:]

STATEMENT OF JOSEPH P. NEWHOUSE
CHAIRMAN
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good Morning, Mr. Chairman. I am Joseph Newhouse, and I am pleased to be here for the first time as Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Dr. Donald Young, the Executive Director of ProPAC. On March 1st, the Commission submitted to the Congress its eleventh annual report containing recommendations for improvements to the Medicare program. This morning, I am briefly going to discuss these recommendations, which were developed by the Commission before I became Chairman. During my testimony, I will refer to several charts. These charts are appended to the end of my testimony.

Since 1965, the Medicare program has provided financial protection from the high costs of illness to individuals age 65 and over and, beginning in 1972, to many disabled people, as well as those with end-stage renal disease. This protection for the elderly and disabled, however, has come at a substantial cost to the Federal government and taxpayers and to many Medicare beneficiaries. Medicare program spending climbed from $4.8 billion in 1967 to an estimated $177 billion in 1995. This rapid rise in expenditures is contributing to the Federal deficit, threatening the solvency of the Hospital Insurance Trust Fund, and is a growing burden to Medicare beneficiaries, who share in the costs of the program.

SLOWING MEDICARE SPENDING GROWTH

The Commission supports the efforts of this Committee to rein in the growth in Medicare expenditures. ProPAC believes spending for medical services in a private sector with market forces that encourage cost containment and high quality care provides a benchmark for the Medicare program. Judgments regarding appropriate spending levels and rates of increase, however, should be based on several years' experience to account for short-term factors that may give a misleading picture of the trends. In addition, spending growth should be compared on a per person basis. It also is important to recognize that the proportion of Medicare enrollees who are disabled or who have end-stage renal disease is increasing faster than the elderly population. The added costs of caring for these people, who require a larger amount of services than the elderly, must also be considered.

The ability to compare and forecast Medicare and private sector spending is a complex task, complicated by substantial data limitations. ProPAC continues to examine available data and methods to assess spending trends, and we will present more on this issue in our report to Congress on *Medicare and the America Health Care System*, which we will submit to you in June.

In the decade beginning in the early 1980s, real Medicare spending per capita (removing the effects of inflation) grew much more slowly than real per capita private insurance expenditures (See Chart 1). More recently, the private sector has outperformed Medicare.

The changes that are occurring in the private sector financing of care are having a substantial effect on the way hospitals and other providers operate. ProPAC has been following closely the factors that contribute to the growth of total hospital expenses (See Chart 2). Two of these factors, general inflation and population growth, cannot be controlled by hospitals. Hospitals have some control over real input prices, which reflect hospital cost inflation above that in the general economy. The utilization of services, that is the number of admissions and outpatient visits, and the intensity and complexity of the care furnished to those who are served, however, can be controlled by hospitals.

Between 1985 and 1992, over half of the growth in hospital costs was due to increases in the intensity of the services furnished to inpatients and outpatients. During this time, changes in hospital utilization had little effect on total cost growth as the overall use of hospital services increased at about the same rate as population growth. From 1992 to 1995, the picture changed dramatically. The number of hospital outpatient visits continued to grow and admission rates began to climb. The most striking finding, however, is the virtual absence of increases in the intensity of services furnished to those who were provided care. Consequently, total hospital costs rose due to general inflation and to increases in the number of people receiving care. But as I will discuss in a few minutes, growth in the costs to provide services to each patient slowed dramatically. We believe that this slowing in the rise of per case

hospital expenses is a response to recent financial pressure from private payers. In addition, much of the increase in utilization is due to a recent acceleration in admission rates for Medicare beneficiaries, rather than private patients.

Increases in the utilization of hospital and other services is responsible for much of the growth in Medicare spending. Constraining the rise in spending is complicated by Medicare's continued reliance on fee-for-service (FFS) payment methods. About 90 percent of Medicare beneficiaries continue to be covered by the traditional FFS program, although enrollment in the risk-based capitation program is growing rapidly (See Chart 3). As of April 1, 1996, there are 202 plans with risk contracts, and applications are pending from another 50 plans.

IMPROVING MEDICARE'S CAPITATION PROGRAM

The Commission strongly supports your efforts, Mr. Chairman, to control spending by reforming the Medicare capitation program and expanding beneficiary choice of health plans. A major flaw in Medicare's current risk contracting program is the wide variability and volatility in payment rates across the country (See Chart 4). In many areas, these rates may discourage plan participation. The variability also results in some Medicare beneficiaries receiving substantial extra benefits that are not available to other beneficiaries. The Commission supports your intent to reduce this variability. We are concerned, however, that even with the modifications you have proposed, the rates may not accurately reflect appropriate costs of care in many areas. We believe that, over time, the rates should better reflect the evolution of market forces that are occurring in each area.

There is another problem with Medicare's capitation program that you are aware of and that must be resolved if the program is to succeed. This is the lack of adequate risk adjustment methods to modify capitation payments to better reflect variations in Medicare enrollees' likely need for medical care. Effective risk adjustment of payments is necessary to prevent unwarranted financial rewards and penalties to plans and incentives to avoid Medicare enrollees with chronic illnesses. It is equally important to ensure that funds are allocated fairly to meet the medical needs of Medicare's beneficiaries enrolled in both the capitation and the fee-for-service programs.

The need to adjust capitated payment rates to reflect the medical condition and service needs of the enrolled population is more important for the Medicare population than for private sector. Medicare beneficiaries are much more likely to have illnesses and disabilities that require costly care. Further, many of these conditions are chronic and easily identifiable.

While the knowledge base in this area continues to be limited, we believe the Secretary should obtain and use available information to make modest improvements in risk adjustment, while vigorously supporting further research. Other approaches to limit risk selection also are necessary, such as the improvements in enrollment and disenrollment policies you included in your proposal.

The lack of good risk adjustment tools also may result in excess Medicare spending for the high deductible medical savings account (MSA) option proposed by the Congress, if healthier beneficiaries select this choice as expected. This undesirable effect could be lessened if Medicare enrollees were required to remain in the MSA option for several years. This option also represents a substantial departure from traditional Medicare policies, and the Commission believes that experience with MSAs should be monitored closely. It is likely that policy modifications will be necessary over time to meet the needs of the Medicare program and its beneficiaries.

As I noted earlier, the Commission strongly supports your intention to offer Medicare beneficiaries a wider choice of capitation and managed care options. The lack of a full range of capitation plans and options and flaws in current policies all have undoubtedly contributed to plan participation and enrollment lagging behind that in the private sector. It is important to recognize, however, that private sector managed care has grown, in part, because many employers no longer offer the choice of a traditional indemnity FFS plan, as Medicare does (See Chart 5). Further, many

Medicare beneficiaries are very comfortable with this traditional program and would be very reluctant to forego this choice. Additional factors, therefore, may also be contributing to the lags in Medicare capitation plan enrollment.

To assist beneficiaries in making the choices that meet their needs, the Commission believes that the Medicare program should expand the information it makes available to them, including clear information on plan benefits, premiums and other cost-sharing requirements, plan performance, and the availability of local providers. In addition, the Secretary needs to continue efforts to identify the information beneficiaries need to make informed health plan choices and the most appropriate format and methods for disseminating these data.

Assuring that Medicare beneficiaries make informed decisions is especially important with the MSA option and the MedicarePlus fee-for-service option. Although these options may be very attractive to some beneficiaries, they also contain the risk of substantial increases in out-of-pocket spending. ProPAC is concerned that some beneficiaries may choose these options without being fully aware of their implications.

A capitation payment system intentionally provides health plans with an incentive to limit the type and number of services delivered. While this is generally desirable as a means to control spending, health plans must be held accountable for the quality of care they provide. In the private insurance market, employers act as an agent for their employees by selecting health plans that will meet their contractual responsibilities and provide access to needed high quality care. The Commission believes that the Medicare program also needs to be vigilant in ensuring that plans meet their responsibilities to provide appropriate care. To do so, measures of health plan performance need to be strengthened and enforced.

THE MEDICARE FEE-FOR-SERVICE PROGRAM

I would like to turn now to a brief summary of ProPAC's recommendations regarding policies in Medicare's traditional fee-for-service program. This program continues to be responsible for about 90 percent of total Medicare spending, and it will continue to provide the funding for the care furnished to a majority of beneficiaries for many years to come. It is important, therefore, that you continue to analyze and appropriately modify these policies to rein in spending growth, while assuring quality care for Medicare's beneficiaries.

INPATIENT HOSPITAL COSTS AND PAYMENTS

When ProPAC appeared before you in September 1995, we noted the dramatic decline in hospital cost growth, which began in the early 1990s. That trend of lower cost growth continues today. From 1984 (the first year of PPS) through 1990, Medicare PPS operating costs per discharge increased at an average annual rate of 9.4 percent (See column 3 in Chart 6). This increase was substantially higher than the growth in PPS payments per case. Consequently, by 1990 PPS inpatient margins, the difference between operating and capital payments and costs as a percentage of payments, had become negative (See Chart 7). Hospital per case cost increases then began to moderate, and in 1993 the average PPS margin again turned positive. In 1994, PPS inpatient costs per case declined by 1.3 percent. We estimate that the average PPS margin will climb to 8.8 percent in 1996, if current trends hold.

This decline in hospital cost growth reflects a dramatic change in the pattern of cost shifting we have previously described to you. In 1992, Medicare's total hospital payments (for the operating and capital costs of inpatient, outpatient, and hospital-based SNF and home health services) covered 89 percent of hospitals' reported costs. In contrast, payments from private payers were 131 percent of costs. By 1994, Medicare's payments had climbed to 97 percent of costs while those from private payers had fallen to 124 per percent (See Chart 8). Based on preliminary data for 1995, we believe that the gap in payment to cost ratios between Medicare and private payers will continue to narrow. The narrowing of the difference in payment to cost ratios reflects the success of private payers in slowing the rise in hospital payments, as well as the slower cost growth resulting from the increased pressure on revenues.

PPS Update

The Commission considered this decline in hospital cost growth as it developed its fiscal year 1997 update recommendation for hospitals paid under Medicare's prospective payment system. The approach we used is the same one we have used over the years. This method accounts for the effects of inflation on hospital costs, changes in the mix and complexity of admissions, added costs of new technology, and hospital productivity improvements. ProPAC's framework supports an update of about market basket minus 1.5 percentage points in fiscal year 1997. In light of the significant changes occurring in health care delivery, including the recent substantial gains in hospital productivity, it may be possible to hold PPS payment rate increases to an even lower level for the next couple of years.

We are concerned, however, about the ability of hospitals to continue to provide high quality care if updates are constrained at this level through 2002. It is unclear how long hospitals will be able to maintain the large productivity improvements we have seen in recent years. ProPAC plans to continue to monitor these trends closely, and we will keep you informed as the findings emerge.

Payment for Capital

The Medicare program is currently halfway through the transition from cost-based to a fully prospective payment system for hospital inpatient capital. The capital payment rates in effect are based on estimated 1992 hospital capital costs per discharge, updated by historical capital cost increases through 1995, subject to a budget neutrality adjustment. Beginning in 1996, the budget neutrality requirement is eliminated, and an update framework is used to adjust the rates. Because of flaws in the data used to calculate the initial rates, together with the updating approach used by the Secretary, actual capital payment rates increased by more than 20 percent in 1996.

The Congress has proposed continuing to link capital updates to projected costs and extending the budget neutrality requirement through 2002. While this would correct for the inappropriate 1996 payment increase, the Commission believes that a better policy would be to break the link between capital cost increases and the update to capital rates. Under such a system, an appropriate base payment rate would be established with updates based on a formula similar to that applied to PPS operating payments.

Payments to Teaching Hospitals

Medicare pays an additional amount to teaching hospitals to recognize the indirect costs of operating approved graduate medical education programs. In fiscal year 1995, these indirect medical education (IME) payments accounted for 5.9 percent of all PPS operating payments, or about $3.9 billion. In addition, Medicare provided about $2.0 billion to hospitals in graduate medical education (GME) payments for the training of interns and residents. Another $400 million was paid for the direct costs of hospital-based nursing and allied health professions training programs.

The Congress has proposed reductions in the level of Medicare IME and GME payments. It also has supported the creation of a new Teaching Hospital and Graduate Medical Education Trust Fund, which includes Medicare's payments as well as general revenues.

ProPAC supports the notion of the trust fund and believes that explicit financial support for the added costs of graduate medical education should not be limited to the Medicare program. The costs of teaching activities are difficult to separate from the costs of patient care, and these hospitals are at a disadvantage in a competitive market because of higher prices relative to their teaching mission. Many of them also care for a large number of uninsured individuals. As competition among hospitals increases, it will be increasingly difficult for many of these teaching institutions to compete for patients from price-sensitive insurers and plans.

In our report, we raise some concerns about the distribution of teaching-related payments as proposed in the Teaching Hospital and Medical Education Trust Fund.

We recommend that funds to provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities for treating all of their patients. Under the current proposal, general revenue funds would be distributed based only on Medicare payment levels in a base year. Hospitals with a high share of Medicare teaching payments would receive a proportionately higher share of these new payments, compared to hospitals with the same amount of teaching activity but less Medicare business.

We also believe that improvements are necessary in the distribution of funds from the proposed MedicarePlus Incentive Account. These payments should allow teaching hospitals to compete effectively in the managed care market and allow plans in Medicare's capitation program to use teaching hospitals as needed. As currently structured, the distribution of these payments would not be related to differences in the intensity or size of hospital residency programs. Also, because the total payments available through this account would be fixed, they would not reflect the actual enrollment of Medicare beneficiaries in the capitation program.

ProPAC is continuing to examine alternative approaches for distributing payments from the Trust Fund to hospitals providing care to Medicare beneficiaries who choose the traditional fee-for-service program as well as those enrolled in the capitation program. We will keep you informed as our work progresses.

The Financial Condition of Teaching Hospitals

The Medicare program plays an important role in assuring that its enrollees have access to the specialized care furnished by teaching hospitals. The effects of Medicare's payment policies, and those of other payers, on the financial condition of these hospitals is demonstrated by their PPS and total margins. In 1994 (PPS 11), the average PPS inpatient margin for major teaching hospitals was 15.6 percent, compared with an average of 0.4 percent for non-teaching hospitals (See Chart 9). Despite the profits from Medicare, however, these hospitals had the lowest total margins of any group at 2.5 percent (See Chart 10). In contrast, the average total margin for non-teaching hospitals was 5.7 percent.

The high PPS margin is due in part to the level of the Medicare IME adjustment being greater than the actual relationship between teaching intensity and costs. ProPAC recommends that this adjustment initially should be reduced from its current level of 7.7 percent for each 10 percent change in the number of residents per bed to 7.0 percent. The final level of the adjustment should depend on the other changes made in the Medicare program. We also believe that the current formula for distributing IME payments needs to be improved, and we plan to examine alternative methods to measure teaching intensity and its relationship to costs.

We also support changes in both Medicare IME and GME policies to encourage an appropriate distribution of residents across specialties and to discourage inappropriate growth in the total number of residents.

Disproportionate Share Hospitals

Medicare also provides a special payment to disproportionate share hospitals (DSH). The DSH adjustment is intended to compensate hospitals that treat large proportions of low-income patients. These payments totaled about $3.8 billion in FY 1995.

During the past year, ProPAC spent a considerable amount of effort attempting to improve the distribution of Medicare payments to these hospitals. The distribution of DSH payments is determined partly by each hospital's Medicaid days as a share of total patient days. Medicaid utilization has always been a poor measure of service to low-income individuals, and its effectiveness will continue to diminish with the changes in the Medicaid program that are taking place.

The Commission has concluded that the objectives of the DSH policies need to be reexamined and the structure of the adjustment modified to make certain that available funds are distributed to the hospitals most in need. This may require

collecting new data to provide a better measure of the services hospitals provide to the indigent.

Many of these hospitals also have teaching programs, and their financial status is similar to that of large teaching hospitals. Due to Medicare's policies, large urban disproportionate share hospitals generally have high PPS margins, but their average total margin in 1994 was only 3.3 percent. With increasing numbers of people lacking health insurance and contraction in state and local programs designed to fund care for them, hospitals' uncompensated care burdens will likely be higher than ever in the coming years. Many of the hospitals that treat a large number of the uninsured, also have substantial Medicare and Medicaid patient loads. ProPAC is concerned that large reductions in DSH payments could threaten the continued ability of many of these hospitals to serve the populations that depend on them for access to care.

POST-ACUTE CARE

Payments to post-acute care providers are the fastest growing component of Medicare expenditures. Rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and home health agencies accounted for 22 percent of Medicare Part A spending in 1993, up from about 7 percent in 1986. This increase in expenditures is driven primarily by a dramatic increase in the utilization of services (See Chart 11).

Changes in Medicare's coverage policies account for some of the increased use of post-acute services, but Medicare payment policies also encourage growth in utilization. Medicare's PPS provides incentives for hospitals to reduce lengths of stay by moving patients quickly to post-acute settings. In response to these incentives, many hospitals have moved into the business of furnishing post-acute care. Medicare's policies also have encouraged the increase in the number of free-standing facilities.

Medicare has modified its policies over the years to slow the rise in payment per unit of service furnished. The ability to control the number of services furnished, however, has remained elusive. The overlap of similar services across different types of providers, the lack of a uniform definition of service units, variation in payment policies based on type of provider, and absence of good measures to assess the value and outcome of the services provided all have contributed to the difficulties in correcting the problem.

The Commission strongly supports the implementation of prospective payment systems for post-acute services. The prospective payment should cover all of the services furnished over an appropriate episode of care. Policies that link payment for inpatient hospital care with post-acute care should also be explored. Options to examine include bundling acute and post-acute services for certain DRGs into a single rate and developing DRGs that reflect the use of post-acute services.

Ultimately, it may be possible to implement a single system that could be used across all providers. If this is not feasible, the Commission believes that the payment methods and incentives should be consistent across all delivery sites. HCFA has been sponsoring research and demonstration projects to develop prospective payment systems for post-acute services for a number of years. Despite the similarity in services furnished by these providers, these projects have not been coordinated. In addition, much of their focus has been on per diem or per unit payment techniques. These types of prospective payment systems will do little to control the major problem driving expenditure increases, the growth in service volume.

It is especially important that HCFA coordinate the development of case-mix measures for post-acute services furnished by all types of providers, over an episode of care. Reliable case-mix measurement systems are necessary to account for patient characteristics that affect resource use. Further, they allow for comparisons of service use and expenditures across beneficiaries and across providers.

Interim Improvements in Skilled Nursing Facility and Home Health Policies

The Commission supports the implementation of interim payment methods to control the growth in routine and ancillary services furnished by skilled nursing facilities until a comprehensive prospective payment system is established (See Chart 12). The Commission notes, however, that interim payment limits should be designed that do not unduly restrict this evolving industry. Basing prospective payments on facility-specific or average national base payments has important deficiencies, and the Commission suggests that alternative methods should be explored. These could include calculating payments based on a larger geographic area or using a blend of facility-specific and regional rates to establish the appropriate payment amount.

ProPAC also recommends the use of episode-based payment limits for home health services until a fully prospective payment system can be implemented. Since 1990, the number of visits furnished to each person served has grown rapidly (See Chart 13). In addition, beneficiary copayments, subject to an annual limit, should be introduced. The Commission believes that it is appropriate initially to blend regional and national costs to establish prospective limits. It is concerned, however, that maintaining regional variations in the payment amounts would perpetuate unjustified differences in utilization and expenditures across geographic areas. The Commission, therefore, recommends a transition from regional to national rates, as was used in establishing hospital prospective payment rates.

HOSPITAL OUTPATIENT SERVICES

The Commission continues to recommend that a comprehensive prospective payment system for all hospital outpatient services should be implemented as soon as possible. Because almost all services provided in the hospital outpatient setting can be obtained from other ambulatory providers, consistent payment policies should be established across all settings. To constrain growth in the number of services provided, a strategy for controlling volume is also necessary. Imposing volume controls on hospital outpatient services only, however, could lead to a shift in services to other sites. Ultimately, therefore, volume control methods should apply to all ambulatory providers.

ProPAC also recommends that the growing financial burden for Medicare enrollees who receive services in hospital outpatient departments should be alleviated. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary could estimate beneficiary copayments since they cannot be calculated precisely when services are delivered.

The Commission is aware, Mr. Chairman, that reducing beneficiary coinsurance would increase Medicare outlays. This increase could be offset in part by correcting current flaws in the hospital outpatient blended rate formula, as the Congress has proposed. If necessary, the reduction in beneficiary liability could be phased in over several years.

UPDATE TO THE COMPOSITE RATE FOR DIALYSIS SERVICES

Medicare spending for end-stage renal disease (ESRD) beneficiaries is growing rapidly. A large part of the increase is due to an expanding ESRD population. But these beneficiaries also are using more acute care, home health, and other dialysis-related services. A comprehensive payment method that includes a broad array of services should be explored. Most ESRD beneficiaries are not eligible to enroll in Medicare's risk program. These individuals should be allowed to enroll in Medicare's expanded capitation program, with suitable payment adjustments, or a separate capitation program should be established.

In the interim, the Commission has concluded that the composite rate for hospital-based dialysis facilities should be updated by 2.7 percent and for free-standing facilities by 2.0 percent. This recommendation is based on our analysis of available Medicare cost report data as well as a comprehensive review of the literature related to quality of care for dialysis patients. Unlike Medicare payments to other providers, the composite rate has not been updated for many years. The Commission

is concerned that many dialysis facilities may not be able to continue to provide quality services without an update to the payment rate. Unfortunately, information is not available to accurately assess the relationship between payments and quality of dialysis care. The Commission, therefore, recommends that the Secretary develop reliable measures to analyze the relationship among treatment processes, patient outcomes, and costs. These factors are critical to evaluate the need for and the level of future payment updates.

THE FAILSAFE BUDGET MECHANISM

As I have described, spending in the fee-for-service program continues to grow rapidly. This program directly pays hospitals, physicians, and other providers for the care they furnish. The more care these providers give, the more they get paid. Consequently, even when Medicare controls the price it pays for each unit of service, spending escalates as the number of services increases.

To assure that fee-for-service spending would not exceed budget targets, the Congress included a "failsafe budget mechanism" in the bill it passed. The failsafe mechanism would allocate a fixed benefit budget (based on the number of enrollees) for both Medicare's capitation and FFS programs. If spending in any of the nine major FFS provider sectors exceeded budget targets, in subsequent years payments to providers in the sector would be reduced to bring spending back in line with the target. This mechanism would ensure that Medicare spending would not exceed the targets set by the Congress.

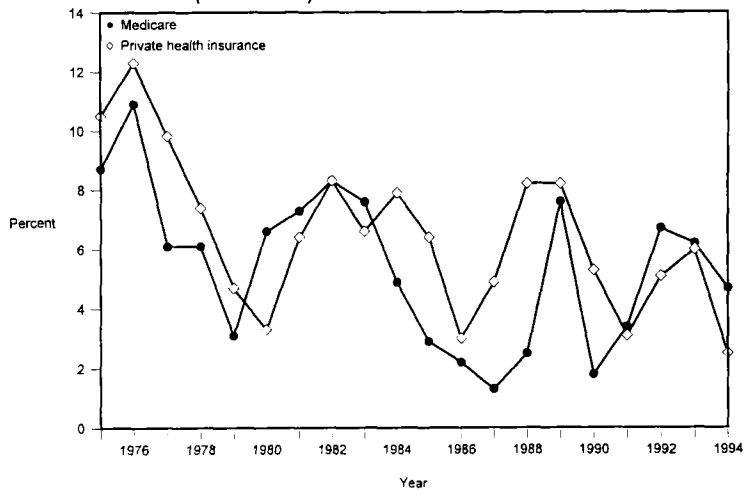
The Commission is concerned, however, that the failsafe mechanism could have unintended consequences. The major problem in allocating a budget between the traditional fee-for-service and capitation programs is the same one I mentioned earlier in regard to the capitation program and that is the lack of robust risk adjustment methods to set capitation payments. The adjustment methods currently used in Medicare's risk contracting program are limited in their ability to account for increases in patient complexity and severity of illness. Thus, if healthier enrollees were to select Medicare's capitation program, per enrollee payments could be high relative to the needs of this population, with payments in the traditional fee-for-service program that are too low.

The Commission also is concerned that there is no provision to adjust the benefit budget if future inflation differs notably from CBO's forecast. Further, the spending allocations across fee-for-service sectors would be determined by projected expenditures based on past spending patterns. This type of failsafe mechanism thus could lead to payment inequities among provider groups as patterns of care continue to change. The Balanced Budget Act recognizes that adjustments to the failsafe mechanism would be needed over time, and ProPAC would be pleased to assist you with the analytic work necessary to ensure payment equity between the capitation and fee-for-service programs in future years.

CONCLUSION

This concludes my formal statement, Mr. Chairman. I realize that I have covered a wide range of complex policies that ProPAC has considered over the past year, and I would be pleased to answer any questions you or the members of the Subcommittee may have. In many cases, as I indicated, we are continuing to work on these issues, and we will keep you and your staff informed of our progress.

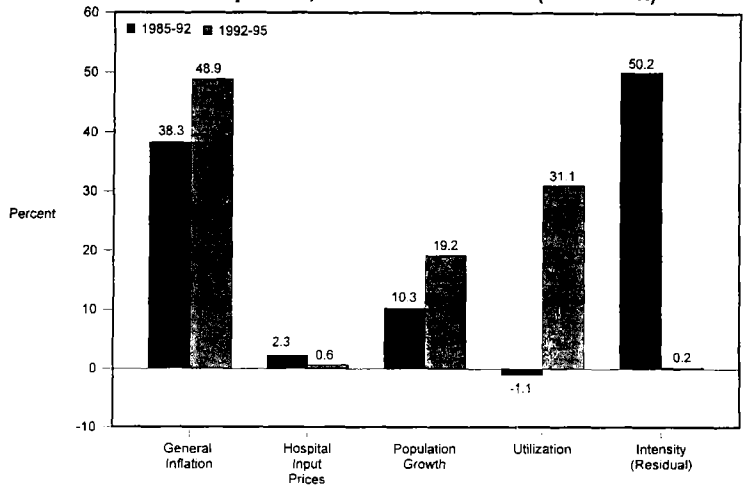
Chart 1. Change in Real Per Capita Medicare and Private Health Insurance Expenditures, 1975-1994 (In Percent)



Note: Expenditures are adjusted using the consumer price index for all urban consumers.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 2. Factors Contributing to the Growth of Total Hospital Expenses, 1985-92 and 1992-95 (In Percent)



SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Chart 3. Medicare Risk Program Participation, 1990-1996

Year	Enrollees: Number (In Millions)	Enrollees: As a Percentage of Total Medicare Enrollment	Contracts
1990	1.2	3.5%	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996	—	—	189

Note: Enrollment data are as of September each year; contract data are as of January each year.

SOURCE: Health Care Financing Administration, Office of the Actuary and Office of Managed Care.

Chart 4. Deciles of County AAPCC Values, All Counties, 1995

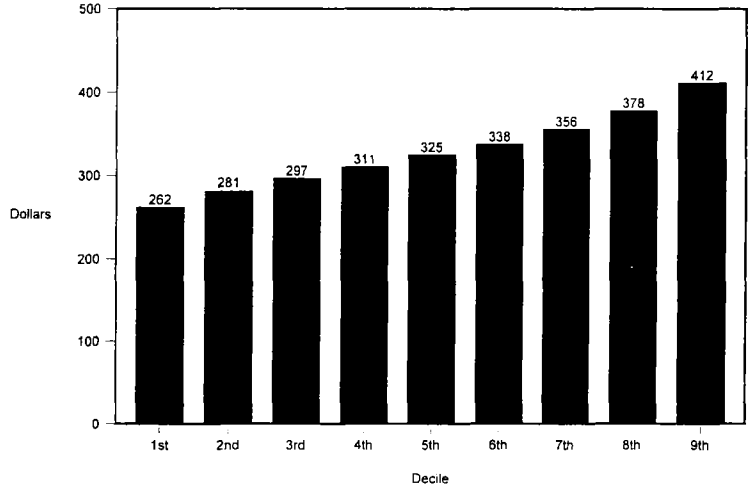
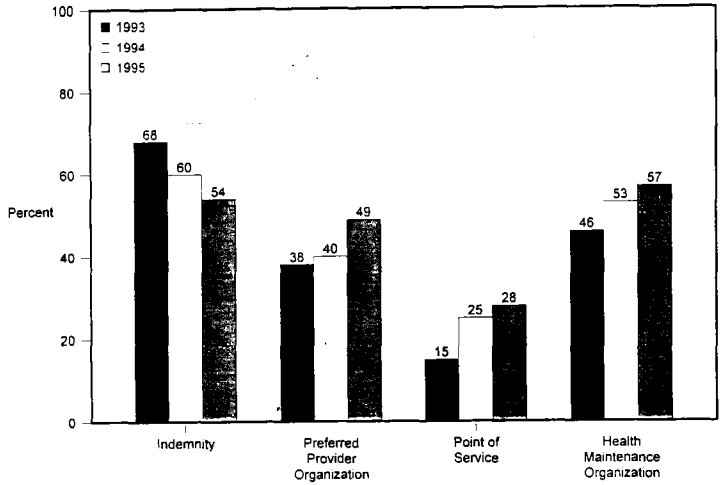


Chart 5. Percentage of Large Employers Offering Selected Health Plans, 1993-1995



Note: Large employers are those with 500 or more employees.

SOURCE: A. Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1995.

Chart 6. Annual Change in PPS Operating Costs and Payments, First 11 Years of PPS (In Percent)

Year	PPS Costs and Payments						Consumer Price Index[2]
	Operating Costs	Payments	Operating Costs Per Case	Payments Per Case	Market Basket Index	Update Factor[1]	
PPS 1	-4.6%	11.0%	1.8%	18.5%	4.9%	4.7%	4.1%
PPS 2	4.7	4.2	11.0	10.5	3.9	4.5	3.7
PPS 3	5.6	-0.5	9.7	3.4	3.9	0.5	2.5
PPS 4	7.4	3.9	8.9	5.3	3.5	1.2	2.9
PPS 5	9.8	6.7	9.0	6.0	4.7	1.5	4.1
PPS 6	10.4	7.7	9.3	6.6	5.5	3.3	4.7
PPS 7	10.5	8.2	8.6	6.3	4.6	4.7	5.0
PPS 8	9.0	8.0	6.9	5.8	4.3	3.4	5.1
PPS 9	7.0	7.3	4.9	5.2	3.1	3.0	3.0
PPS 10	3.5	5.9	1.3	3.6	3.0	2.7	3.1
PPS 11	0.3	5.2	-1.3	3.5	2.4	2.0	2.6

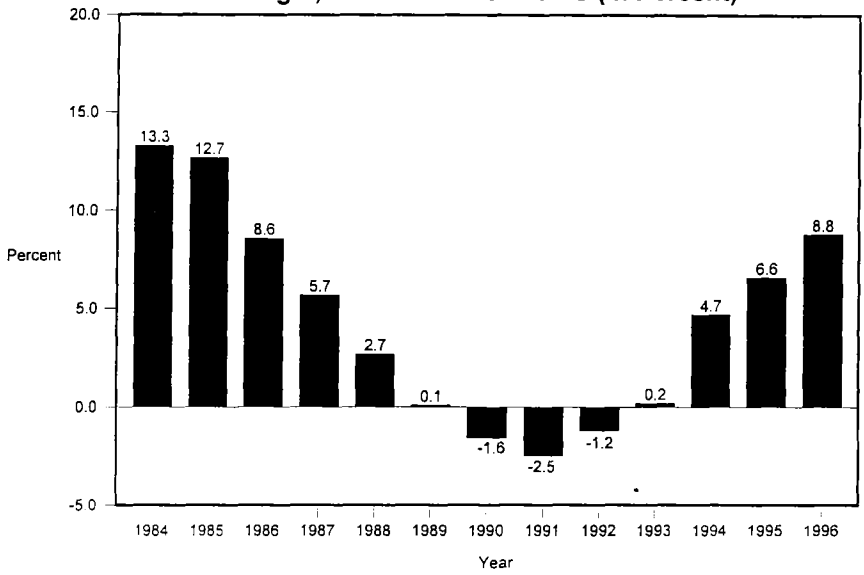
Note: Data on costs, payments, and discharges for each PPS year (PPS 1, etc.) correspond to each hospital's cost reporting period beginning in that Federal fiscal year. For instance, PPS 1 data are from hospitals' cost reports beginning during the first year of PPS (fiscal year 1984). Data on the market basket index, the update factor, and the consumer price index are from the corresponding Federal fiscal year (1984 for PPS 1, etc.). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with PPS 3 and New Jersey beginning with PPS 6. Changes are based on cohorts of hospitals with cost reports available in each of two consecutive years.

[1] Average update factor beginning with PPS 5 (fiscal year 1988). Update factor for PPS 7 (fiscal year 1990) adjusted for 1.22 percent across-the-board reduction in diagnosis-related group weights.

[2] Increase in the average consumer price index for all urban consumers for the corresponding Federal fiscal year.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration and the Bureau of Labor Statistics.

Chart 7. Aggregate PPS Inpatient (Operating Plus Capital) Margin, First 13 Years of PPS (In Percent)



Note: PPS margin estimated for 1995 and 1996.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 8. Hospital Payment to Cost Ratios for Medicare, Medicaid, and Private Payers, 1980-1993

	Payment to Cost Ratio		
Year	Medicare	Medicaid	Private
1980	0.96	0.91	1.12
1981	0.97	0.93	1.12
1982	0.96	0.91	1.14
1983	0.97	0.92	1.16
1984	0.98	0.88	1.16
1985	1.01	0.90	1.16
1986	1.01	0.88	1.16
1987	0.98	0.83	1.20
1988	0.94	0.80	1.22
1989	0.91	0.76	1.22
1990	0.89	0.80	1.27
1991	0.88	0.82	1.30
1992	0.89	0.91	1.31
1993	0.89	0.93	1.29
1994	0.97	0.94	1.24

Note: Payments and costs include both inpatient and outpatient services. These ratios cannot be used to compare payment levels, because both the mix of services and the cost per unit of service vary across payers. They do, however, indicate the relative degree to which payments from each payer cover the costs of treating its patients. Due to reporting inconsistencies related to Medicaid disproportionate share payments and provider-specific taxes, there are significant margins of error for the numbers related to all payers in 1992 and 1993.

SOURCE: ProPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

Chart 9. PPS Inpatient Margin, by Hospital Group, First 11 Years of PPS (In Percent)

Hospital Groups	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10	PPS 11
All hospitals	13.3%	12.7%	8.6%	5.7%	2.7%	0.1%	-1.6%	-2.5%	-1.2%	0.2%	4.7%
Urban	14.3	13.6	9.6	6.6	3.3	0.6	-1.3	-2.3	-1.2	0.4	5.4
Rural	7.7	7.3	2.2	0.2	-1.3	-2.9	-3.8	-3.8	-1.6	-1.0	0.6
Large urban	15.0	13.5	9.8	6.6	3.0	0.4	-0.8	-1.5	0.1	1.9	7.3
Other urban	13.4	13.7	9.3	6.6	3.6	0.9	-2.0	-3.5	-3.2	-1.9	2.3
Rural referral	9.5	12.4	7.9	5.5	3.3	0.5	-1.1	-1.5	1.4	0.6	3.1
Sole community	8.2	6.5	2.0	0.4	-1.3	-2.6	-1.0	-0.6	2.8	4.4	5.5
Other rural	7.0	5.9	0.1	2.0	-3.2	-4.4	-5.8	-5.9	-4.4	-3.8	-2.5
Major teaching	18.1	18.1	14.9	12.5	10.3	7.2	7.1	7.5	8.8	10.1	15.6
Other teaching	14.8	14.6	10.4	7.2	3.8	1.5	-0.9	-2.1	-1.3	0.3	4.8
Non-teaching	11.2	10.0	5.2	2.5	-0.7	3.3	-5.2	-6.4	-5.0	-3.7	0.4
DSH:											
Large urban	15.4	13.7	10.3	8.1	5.7	3.4	3.1	2.9	4.8	7.1	12.8
Other urban	13.4	14.3	10.1	7.9	5.2	2.5	0.1	-1.3	-1.1	0.3	4.4
Rural	8.3	8.7	3.4	0.9	-0.2	-2.4	-3.3	-2.9	-1.2	-1.4	0.7
Non-DSH	12.4	11.6	7.1	3.5	-0.5	-3.1	-5.6	-6.8	-5.6	4.6	-0.6
Teaching and DSH	15.9	15.6	12.1	0.0	7.8	5.3	4.3	3.8	4.8	6.6	11.7
Teaching only	15.3	15.6	11.3	6.7	1.9	-0.7	-3.5	-4.2	-3.2	-2.3	2.0
DSH only	11.5	10.7	6.0	3.6	0.9	-1.6	-3.1	-4.0	-2.4	-0.8	3.5
No teaching or DSH	10.9	9.4	4.5	1.5	-2.0	-4.6	-6.9	-8.5	-7.2	-6.2	-2.2
Voluntary	13.8	13.4	9.4	6.4	3.1	0.7	-1.4	-2.5	-1.4	-0.1	4.1
Proprietary	13.0	11.2	6.6	3.7	0.0	-3.7	-5.4	-4.3	-1.9	1.0	8.7
Urban government	13.0	12.7	8.1	6.2	4.9	1.9	2.2	1.1	1.9	3.7	9.4
Rural government	6.6	4.9	0.8	-2.6	-2.7	-4.1	-4.5	-4.7	-2.9	-2.8	-2.7

Note: Data for each PPS year are from hospital cost reporting periods beginning during that Federal fiscal year. For instance, PPS 1 data are from hospitals' cost reports beginning during the first year of PPS (fiscal year 1984). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with PPS 3 and New Jersey beginning with PPS 6.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 10. Total Hospital Margin, by Hospital Group, First 11 Years of PPS (In Percent)

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10	PPS 11
All hospitals	7.1%	6.4%	4.2%	3.5%	3.3%	3.5%	3.5%	4.4%	4.3%	4.3%	4.8%
Urban	7.5	6.7	4.4	3.6	3.4	3.4	3.4	4.3	4.2	4.2	4.7
Rural	4.8	4.5	2.9	2.7	3.2	4.0	4.4	5.0	5.2	5.2	5.5
Large urban	7.2	6.4	3.9	3.1	2.7	2.8	2.3	3.5	3.6	3.6	3.8
Other urban	8.1	7.2	5.3	4.6	4.4	4.6	5.2	5.6	5.3	5.3	6.1
Rural referral	7.5	8.4	6.0	6.0	5.5	6.4	6.8	6.6	6.4	6.4	6.9
Sole community	4.6	3.9	2.3	1.9	2.1	3.1	3.7	5.0	5.2	5.2	5.8
Other rural	4.0	3.5	2.0	1.8	2.7	3.4	3.7	4.4	4.7	4.7	4.7
Major teaching	4.5	5.2	2.1	2.2	2.1	1.7	0.8	3.6	3.3	3.3	2.5
Other teaching	8.2	7.3	5.3	4.3	4.0	4.5	4.2	4.5	4.3	4.3	5.0
Non-teaching	7.3	6.2	4.4	3.6	3.4	3.7	4.2	4.7	4.8	4.8	5.7
DSH:											
Large urban	6.3	5.5	2.9	2.2	1.8	2.1	1.3	2.9	3.1	3.1	3.3
Other urban	8.0	7.1	5.4	4.6	4.5	4.7	5.2	6.0	5.8	5.8	6.4
Rural	5.4	5.7	3.0	3.2	3.6	4.5	5.2	7.0	7.0	7.0	5.8
Non-DSH	7.4	6.8	4.8	4.1	4.0	4.0	4.2	4.5	4.4	4.4	5.0
Teaching and DSH	6.4	5.9	3.4	3.0	2.6	3.0	2.4	3.9	3.8	3.8	3.9
Teaching only	8.7	8.2	5.7	4.7	5.0	4.3	4.2	4.7	4.1	4.1	4.4
DSH only	7.8	6.5	4.5	3.3	3.4	3.5	4.1	5.1	5.2	5.2	6.1
No teaching or DSH	6.8	6.0	4.3	3.7	3.5	3.8	4.3	4.3	4.5	4.5	5.3
Voluntary	7.7	6.9	4.7	3.7	3.6	3.8	3.8	4.2	4.0	4.0	4.6
Proprietary	8.5	7.6	5.4	4.6	3.4	2.7	3.6	5.2	6.2	6.2	8.7
Urban government	3.6	3.8	0.9	2.2	1.9	2.5	1.7	4.5	4.4	4.4	3.2
Rural government	4.5	2.8	1.8	1.1	2.2	3.0	3.5	4.8	5.3	5.3	4.7

Note: Data for each PPS year are from hospital cost reporting periods beginning during that Federal fiscal year. For instance, PPS 1 data are from hospitals' cost reports beginning during the first year of PPS (fiscal year 1984). Excludes hospitals in Maryland; includes hospitals in Massachusetts and New York beginning with PPS 3 and New Jersey beginning with PPS 6. DSH = disproportionate share.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 11. Medicare Utilization for Selected Part A Services, 1986-1993

Year	Admissions Per 1,000 Beneficiaries[a]			Persons Served Per 1,000 Beneficiaries[b]	
	PPS Hospital	Rehabilitation	Long-Term Care	Skilled Nursing	Home Health
1986	316.5	2.9	0.4	9.8	50.9
1987	304.4	3.3	0.4	9.3	49.2
1988	298.7	3.7	0.5	11.9	49.1
1989	288.0	4.0	0.5	19.4	51.3
1990	285.6	5.0	0.5	19.0	57.9
1991	284.7	5.9	0.5	19.6	64.9
1992	285.5	6.6	0.6	22.4	72.1
1993	285.3	7.2	0.7	25.4	80.3
1994	—	—	—	25.9	91.3
1995	—	—	—	26.7	97.4
Percent change					
1986-1993	-9.9%	148.3%	75.0%	150.0%	60.8%

[a] Admissions per 1,000 beneficiaries counts all admissions, not the number of beneficiaries who were hospitalized at any time during the year.

[b] Persons served per 1,000 beneficiaries counts the number of beneficiaries who were provided the service in a given year, not the number of admissions.

SOURCE: ProPAC analysis of Medicare Cost Reports and data from the Health Care Financing Administration.

Chart 12. Medicare Skilled Nursing Facility Payments and Utilization, 1983-1994

Year of Service	Skilled Nursing Facility		People Served		Days	
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	$0.5	—	265	9	9,314	35.1
1984	0.6	6.9%	299	10	9,640	32.2
1985	0.6	2.9	314	10	8,927	28.4
1986	0.6	0.2	304	10	8,160	26.8
1987	0.6	8.8	293	9	7,445	25.4
1988	0.9	47.1	384	12	10,667	27.8
1989	3.5	275.7	636	19	29,780	46.8
1990	2.5	-29.0	638	19	25,139	39.5
1991	2.9	18.4	671	20	23,651	35.3
1992	4.5	55.3	785	22	28,971	36.9
1993	6.4	42.8	906	25	34,332	39.6
1994*	8.3	28.5	945	26	36,926	39.9
1995*	10.3	23.8	990	27	38,756	41.0

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 13. Medicare Home Health Care Payments and Utilization, 1983-1994

Year of Service	Medicare		People Served		Visits	
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	$ 1.6	—	1,318	45	36,898	28
1984	1.9	17.5%	1,498	50	40,422	27
1985	1.9	4.0	1,549	51	39,449	25
1986	1.9	-0.5	1,571	51	38,000	24
1987	1.9	-1.2	1,544	49	35,591	23
1988	2.0	8.6	1,582	49	37,132	23
1989	2.6	23.8	1,685	51	46,199	27
1990	3.9	53.2	1,940	58	69,532	36
1991	5.6	45.6	2,223	65	100,226	45
1992	7.9	40.5	2,523	72	135,612	53
1993	10.3	30.0	2,888	80	169,377	60
1994*	13.4	30.7	3,325	91	221,890	65
1995*	16.0	19.0	3,615	97	252,341	—

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chairman THOMAS. Thank you very much, Dr. Newhouse.

There is a rather dramatic difference in terms of the hospital margins as proposed by some studies that had been done. However, I want to try to put this in its proper context.

Let's look at your chart 7 from 1993 to 1996. Would PPS payments have been increasing at a declining percentage, holding steady, or decreasing?

Mr. NEWHOUSE. On chart 6, the PPS payments per case over there in the fourth column have been decreasing through PPS–11, which is 1994.

Chairman THOMAS. The cost per case has been going down.

Mr. NEWHOUSE. Correct.

Chairman THOMAS. So the relative increase has been the difference between the hospital's rather dramatic ability to hold down costs, notwithstanding the declining payments.

Mr. NEWHOUSE. That is correct.

Chairman THOMAS. The assumption, then, is that that is a finite relationship. They can only go so far.

Why has it occurred in the 1993–96 period and it didn't occur in the 1989–93 period? Do we have any feeling for that at all?

Mr. NEWHOUSE. Well, that is necessarily speculative, Mr. Chairman. The Commission feels that it is increased pressure from private payers that has been the principal factor responsible here.

Chairman THOMAS. I think it is a response to the real world, and my question would be, although you indicated 1.5 percent, would a market basket of minus 2 percent be out of the question, at least for the next several years?

Mr. NEWHOUSE. The Commission indicated in its report that market basket minus 2 points would have been reasonable, at least within the framework it used. How long hospitals could sustain that is speculative. I think we will just have to see how things go as we go along.

Chairman THOMAS. If you might in just a minute or two, give us ProPAC's response to the whole question of graduate medical education.

Mr. NEWHOUSE. Yes.

Chairman THOMAS. As you know, we suggested a fundamental new way of dealing with the issue. I guess the easiest way is to simply talk about utilizing Medicare as an ongoing base for financing graduate medical education, appropriate or inappropriate.

Mr. NEWHOUSE. As you know, the Commission recommended a decrease in the add-on, as it were, for teaching hospitals from 7.7 to 7.0 percent and believes that that should head downward in the future.

It also supported the notion of the trust fund, and the Commission believed that there ought to be considered, anyway, an all-payer system for graduate medical education.

Chairman THOMAS. Has there been an ongoing discussion about the whole question of whether or not Medicare should be budgeted and the dollar amounts?

Mr. NEWHOUSE. I was not present for the Commission's deliberations this past year. So I might ask Don Young to comment on that.

Chairman THOMAS. Have you since coming on as Chairman had any discussions?

Mr. NEWHOUSE. No. I have been Chairman for one meeting. So we have not had any discussions of budgeting, at least not in that session.

Chairman THOMAS. In for a dime, in for a dollar. Either in for a dime or for an open-ended entitlement, you have got to make a decision.

Any continued discussion? I know there was some concern in looking at some of the proposals about the idea of dealing with an ultimate absolute amount that might be structured in the program.

Dr. YOUNG. Yes. The Commission was concerned by the continued growth and particularly the continued growth in the number of residents that was driving that spending, and that growth and the number of residents was coming at a time when manpower experts believed that we should not be increasing the number of residents to that amount. So they were interested in finding ways to ensure that the Medicare contribution, but contributions overall, met manpower needs and other needs that were in the country. At the same time, they were very concerned about the hospital portion as opposed to the manpower portion because that group of hospitals also tended to be hospitals that treated a large number of the uninsured and of the poor. So those two things tended to balance each other in the Commission's discussion and deliberations.

Chairman THOMAS. Thank you.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, and welcome to so many of you at the table for the information that you have been able to provide over the last year as we have worked to look at how to go about reform.

Whether we pass a Medicare reform bill or whether we don't, is the Commission planning to do some analysis of the impact of reducing reimbursement rates to first certification or lowering them for work beyond first certification, or how we would go about allocating the medical education dollars as we effect a downsize in the number of residencies that we support, so that we preserve our major medical centers and don't simply divide the dollars equally of the whole system?

That whole issue of how you allocate the dollars, if you can no longer allocate them through patients treated, is an issue that we have not addressed, and I wonder if that kind of issue, as there are four or five different issues in the medical education area, if you are planning any studies in that area.

Mr. NEWHOUSE. That is a very good question. The Commission, first of all, was concerned that the trust fund dollars not be allocated strictly in accordance with Medicare activity, but with respect to all teaching activity. It thought that teaching hospitals with a high share of Medicare patients shouldn't be better off than a similar teaching hospital with a lower share.

This also ties up with another issue that we are going to have to take up, I think, next year, although we won't settle our work plan until June, but that is the overlap between the teaching payments and the disproportionate share payments.

The disproportionate share payments are now allocated in part, as you know, on the percentage of Medicaid admissions or admis-

sions of Medicaid patients. As several States are moving toward less restrictive eligibility in their Medicaid Programs, this is becoming an increasing problematic method of distributing the disproportionate share payments, and because those go heavily to teaching hospitals, there is a disproportionate share somewhere, but not here. It is a high proportion of disproportionate share payments, 66 percent, that go to teaching hospitals. How that is resolved will have an effect on teaching hospitals.

Mrs. JOHNSON. Both of those are very important issues. I hope, also, that you are going to look at the issues that are raised simply by adapting a freeze on the number of residency positions, and the impact of this freeze on urban hospitals or that approach on urban hospitals and the combination of that kind of a freeze with a change in the funding for advanced levels of certification.

I hope that as you plan your work for the next year that you will also help us look at the issues raised in that area as well.

The last issue that I wanted to raise, and there are a number of issues in particular that concern me in regard to reimbursement rates for home health care and nursing homes, but rather than going in that direction, I would like to hear you talk a little bit about capitation rates versus premium rates.

I believe there is a strong case to be made for enabling Medicare to pay premiums if we are going to bring managed care plans into the Medicare system. There is a difference between premiums in my estimation and capitation. Would you agree or disagree?

Mr. NEWHOUSE. I am sorry. I am not clear on the distinction you are making.

Mrs. JOHNSON. Capitation tends to look at a bundle of services. If it rises to a bundle of the total Medicare package, like the AAPCC concept, then it becomes a premium, but if you look at the history of payment policy in Medicaid, you can only conclude that poor payment policy can destroy health care access and quality.

Seeing some of that happening in Medicare, I personally am not very comfortable with our bundling services and moving toward capitation.

In general, the economic theory that costs should not be related to product is, I think, a poor theory, and where we have used that in our reimbursement policy in Medicare, I think we have gotten in trouble.

Premiums, however, are not unrelated to capitation. On the other hand, since they are market basket-oriented for the total bundle of services, they tend to be less dangerous, if they are honestly set.

So I think this is an area where I would like a lot more information before we move forward.

Mr. NEWHOUSE. I am not sure this answers your question, but I would only observe on the capitation side or the at-risk side of the program that as long as you have organizations offering zero premium packages, you could probably infer that you are going to avoid the Medicaid kind of problem you are worried about.

Mrs. JOHNSON. Right. At that point, the capitated payment becomes a premium. Below that, it doesn't. So I realize I haven't asked my question very sharply, but it is an area that I need to

know more about and get into more because I think we could do this wrong.

Thank you.

Chairman THOMAS. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Newhouse, in your report, you do address the old question of medical savings accounts, and I know that was part of the Medicaid/Medicare proposal, which I personally had some problems with. Would you review for the Committee what the upshot of those findings were, regarding MSAs for the Medicare population?

Mr. NEWHOUSE. Yes. The Commission had some concerns that, as proposed, the medical savings account could lead to selection against the Medicare fee-for-service program; that is, the better risks would opt for medical savings accounts, but the degree of that selection is difficult to estimate and is probably going to depend on the length of the lock-in period for the medical savings account. The Commission recommended that there be a reasonable lock-in period as a protection against selection.

Mr. KLECZKA. Does the Commission have a recommendation on that lock-in period?

Mr. NEWHOUSE. The length of the lock-in period?

Mr. KLECZKA. My amendment before the Committee was 5 years, which did not prevail, but I thought that was a reasonable period of time.

Mr. NEWHOUSE. I am trying to recall, since I wasn't there when this recommendation was formulated.

Mr. KLECZKA. Dr. Young.

Dr. YOUNG. The Commission did not come up with a year recommendation, but they thought it should be substantial, and during the discussion, the discussion focused on 4 or 5 years as an example, but they did not come up with a specific year.

Mr. KLECZKA. Can you translate your research on the medical savings account to the general population since, as we all know, the MSA is part of another piece of legislation moving through Congress, the Kassebaum-Kennedy bill? Would that same adverse selection happen to the general population as we know or suspect it could happen to the Medicare population?

Mr. NEWHOUSE. I don't believe the Commission has tried to project outside the Medicare context, and clearly, the general population context is a different context.

Mr. KLECZKA. I think you still might get some of the same adverse selection and things of that nature.

Thank you, Mr. Chairman.

Chairman THOMAS. I will just tell the gentleman briefly that the idea of talking about extending the period of time that you have to be enrolled or the notification for exit is one approach. Some of us have been exploring requiring monthly or quarterly examinations of the profile on the risk selection to a program like an MSA, setting up an early warning signal system in terms of enrollments or not enrollments since we know so little about the area. A lot of it is speculative, but it seems to me that you can monitor who is coming in, and to the degree they have a risk profile that fairly fits the general population, you wouldn't be concerned. To the degree

that they didn't, you would. I think this kind of information would be invaluable in getting a better feel not just for the seniors, but for the others as well.

The point being, I think there are a number of ways for us to resolve some concerns about the disturbance that an MSA might bring about to the current risk selection structure.

Mr. KLECZKA. Once you see the adverse selection or something like it, such as the excess spending, would you then cut off enrollment?

Chairman THOMAS. You could talk about either slowing down or cutting off enrollment.

Mr. KLECZKA. If I am next in line, I am not going to be a happy camper.

Chairman THOMAS. Saying that you have to sign up for 5 years may never make you a happy camper.

Mr. KLECZKA. I think 5 years is fair because, at that point, we are both sharing the risk. You could be healthy for 10 years or 3 years. If this were to go through for the Medicare Program, any retiree in relatively good health would be silly not to take advantage of the MSA for the first 2 or 3 years of retirement, and then as soon as the first ache or pain came about start to get out of it. We talked about that.

Chairman THOMAS. I think now is the time to ask the gentleman from Nebraska if he wants to inquire because I believe he has some views on this as well.

Mr. CHRISTENSEN. I will just make a quick comment. Take my father, for example. I really don't have a question for Dr. Newhouse, but my father recently passed away, and he was 6 months away from being one of those 65-year-olds who was going to be involved with an MSA. He was looking forward to that.

However, in his situation, if he would have gotten sick, his deductible, which would have been around $10,000 for where he was, would have kicked in right away, and all the costs above that would have been covered by the insurance that he purchased.

The idea about the adverse selection, I see, really, as a suspect issue because it is going to be the free market with the private carrier or the catastrophic insurance coming in and the high deductible taking over.

Jerry, I just don't understand where you are coming in with this. I don't agree.

Mr. KLECZKA. If you siphon off all the healthy or healthier individuals?

Chairman THOMAS. Does the gentleman from Nebraska wish to yield to the gentleman from Wisconsin?

Mr. CHRISTENSEN. I would be glad to.

Mr. KLECZKA. If, in fact, the healthy seniors are siphoned off from the Medicare Program for the MSAs, the Medicare Program itself will get stuck with the most unhealthy or the sickest individuals, and naturally, that is going to exacerbate Medicare's costs.

Chairman THOMAS. I will tell the gentleman, we continue to get findings come in. One of the reasons some folks go into HMOs and would probably sign up for MSAs is that they are extremely sick, and it limits their exposure in terms of actual out-of-pocket cost far better than the old-fashioned Medicare structure does. So the de-

bate will continue until we make them available and then we examine what happens in the real world.

Thank you very much, Dr. Newhouse.

We now welcome her certainly not for her maiden voyage, but neither is she a salty dog, the Chairman of the Physician Payment Review Commission, Dr. Wilensky, for her statement, accompanied by Dr. LeRoy, the Executive Director of PPRC, as we say.

Gail.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY LAUREN B. LE ROY, PH.D., EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. WILENSKY. Thank you for not referring to me as a salty dog.

This is the first time I am here to discuss the annual report of the Physician Payment Review Commission, and I am pleased to do so.

This was a somewhat unusual year because of the high level of interest in Medicare, and for the most part, the staff spent the time, and the Commissioners as well, responding to issues that were raised by Members and by your staffs, and that impacted the structure of the report far more than it has in previous years.

What I would like to mention are some of the broad areas that we have covered in this report, and they really divide up into three ways. One are some of the key policy issues that were raised in the Medicare Preservation Act and other discussions that the Congress had.

The second was ways to strengthen traditional Medicare. After all, as much as we may foresee growth in managed care in this area or in medical savings accounts or any other of the choice plans, the fact is that, for the moment, about 90 percent of Medicare beneficiaries are in the traditional fee-for-service program, and so we had some suggestions about how to make that function better.

Finally, there are some issues that relate both to the choice plans and fee-for-service. Let me just mention a few in each of these categories.

It is very important when we talk about broadening choices of plans, for which there was substantial support among the Commissioners, that we recognize it will be urgent to set standards for plan participation and to help seniors get information, so that they can choose well.

We have spent some time talking about the need to set standards that were similar, but that were not necessarily rigid. That is, we tried to acknowledge the fact that because some of the plans were different in their design and structure, that for example, precisely how you go about achieving quality would have to differ.

Further, we spent some time talking about the need to make sure that seniors have information about the process of an annual enrollment, which would make it easier to provide information to seniors.

We also discussed some of the issues related to what would happen if seniors were required to stay in the plan that they chose for as long as 1 year, and some of the need to make sure that market-

ing restrictions that have been in place in the past get put forward into any additional legislation and a mechanism for treating people who indicated in a variety of ways that they didn't understand the choice that they had made.

We spent a substantial amount of time talking about capitation rates. Dr. Newhouse has already talked about this. This was an issue of great concern.

There is concern that has been raised about the volatility of the capitation rates. There has been concern that has been raised by the Congress on about how much they differ from one part of the country to the other, and some of that was dealt with in the legislation that had been proposed. That took one of several choices that we have discussed; that is, putting a floor in place, so that very low rates would cease to exist over time.

In particular, I have had some concern that while that solves one problem of having few plans operating in areas that have had very low capitation rates. There is another concern that as long as traditional Medicare goes along a different path, you might have very different per capita payments in traditional Medicare developing vis-a-vis what would go on in the choice plans. So we need to remember that what we do in one area may have unintended consequences for what goes on in other areas, and it is an issue that we will look at in the next year.

Before I go on, let me talk about medical savings accounts, the issue that was just raised.

This is an issue that the PPRC also looked at. We did not take a position as to whether or not we wanted to advocate having medical savings accounts, although it is certainly a part of the choice structure that was being promoted. But we did raise the issue that adverse selection could cause problems.

We think there are many ways to deal with this. One is the one that was discussed earlier which was having a longer choice period or a longer opt-out period before you go into traditional Medicare or other plans. Another is to make sure that you are monitoring who is going in. In fact, whatever else you do, we think it is important that we monitor the effects of a medical savings account.

There are some very important things that need to be done to fix the traditional Medicare Program. As much as we all wanted to spend time focusing on how to broaden choice under Medicare, we want to remind people that there are things that we can do to make traditional Medicare function better, many of which were included in the legislation that had been passed by the Congress. These include using a single conversion factor and making sure the sustainable growth rate is a concept that is used rather than the volume performance standard, which has arbitrary reductions in payments that over time would impose great burdens on the physician population.

We are also concerned about how practice expense will be implemented; in particular, that a phase-in be used there in the same way that a phase-in was used when the relative value scale for physician work was initially adopted.

So, while we liked to focus on the structural changes in Medicare and in the reform context, I want to make sure that Members re-

member that there are things we need to do to have traditional Medicare function better.

There are changes the private sector has made that may well be useful for traditional Medicare as we broaden choices for the near term at least it will remain a very important program. We have got to do whatever we can to make sure that it functions better.

Finally, the single most important technical issue, for those who are interested in broadening choice to the seniors or to the under 65, has to do with risk selection and risk adjustment. We don't use that as a reason not to open up choices. We use that as a reason to push and promote better ways to make risk adjustment.

PPRC staff has spent a substantial amount of time during the year trying to push forward our technical knowledge. We think there are ways that we can do risk adjustment. HCFA has been pushing forward some of the areas.

Dr. Newhouse, when he was a member of PPRC, had some ideas about mixing a partial capitation with a traditional payment. We think it is important that people understand that risk selection and risk adjustments are technical issues that need to be dealt with rather than excuses for not moving forward in the future.

Thank you.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY
CHAIR
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to be here today to discuss aspects of the Physician Payment Review Commission's 1996 *Annual Report to Congress* that are of interest to this committee. Responding to congressional interest in restructuring Medicare, the report presents recommendations and analyses on key policy issues related to broadening the range of health plan options available to Medicare beneficiaries. Issues covered in the report include methods for setting capitation payments, standards for plan participation in Medicare, facilitating beneficiary choice among plans, promoting quality of care, managed care coverage decisions and the appeals process, and medical savings accounts (MSAs).

The report also focuses on strengthening Medicare's traditional fee-for-service program, still the option chosen by nearly 90 percent of beneficiaries. Our analyses consider the effect of the Medicare Fee Schedule on beneficiary access, evaluate the impact of the fee schedule on physician payments, and assess the Sustainable Growth Rate system proposed by the Congress and the Administration to slow growth in Medicare physician expenditures. The potential for better managing the delivery of care under Medicare fee for service is also discussed.

In addition, we have examined a number of issues that relate to both Medicare managed care and fee for service. These include new analyses of risk selection within Medicare, and an examination of various risk adjustment methods. Other analyses play out the implications of the failsafe budget mechanism included in the Medicare conference agreement. We present initial work on two other issues: changes in secondary insurance for Medicare beneficiaries, and geographic adjustment of Medicare payments. Also explored is the question of how the changing market for health services is affecting the labor market for physicians.

To set the context for these issues, I will begin today by describing some of the important concerns that set the stage for restructuring efforts. I will then briefly outline several key issues included in the report, highlighting the Commission's recommendations to the Congress. We are hopeful that these analyses and recommendations will prove useful as you continue work on Medicare restructuring legislation. As our work progressed over last fall and the winter, Commission staff worked closely with the staff of this committee to provide technical advice in designing the MedicarePlus program and crafting improvements in the traditional program. We look forward to such continued interaction in the months ahead.

Given this subcommittee's recent hearing on physician supply and the financing of graduate medical education (GME), I would also like to take this opportunity to remind you of the Commission's work in this area. Since 1991, the Commission has provided analysis and recommendations on how Medicare could leverage its GME dollars to help achieve broader policy goals. Most recently, we recommended that the capitation payment methodology for Medicare risk-contracting plans be revised so that Medicare payments to providers for medical education costs are removed from capitation payments, and that separate mechanisms be explored for paying plans directly for medical education expenses they may incur in training residents or using teaching facilities. We will consult with committee staff to identify specific options of interest and will keep you apprised as our work progresses.

The Context for Reform

Today, there are many challenges facing the Medicare program. Despite progress in slowing the rate of growth in spending on physicians' services, overall Medicare expenditures continue to increase at a rate many consider unaffordable. Between 1984 and 1993, Medicare expenditures rose at 7.7 percent annually, outpacing growth in most other types of federal spending and in the gross domestic product. Total Medicare expenditures are expected to continue accelerating at annual rates of 8.3 percent to 10 percent from now until 2005. By contrast, projected growth rates for physicians' services expenditures are projected to be in the range of 4 percent to 6 percent.

Also at issue is how to respond to the changing nature of the U.S. health care system, with its growing emphasis on integrated systems of care; capitated payment; and new roles for purchasers, plans, providers, and consumers. Dynamic changes in the private sector have attracted policymakers' attention for several reasons. First, with strong pressure to reduce the federal budget deficit, slowed growth in premiums for private insurance has created expectations that increased penetration of managed care within Medicare will help moderate increases in federal spending. During the late 1980s, private spending was rising faster than Medicare at an average annual rate of 9.7 percent per capita compared with 8.4 percent for Medicare. Since then, this trend appears to have reversed, with private-sector growth rates now below those for Medicare.

The Commission has considered the reasons for the differential in growth rates between Medicare and the private sector. Lower recent rates of increase in the private sector may reflect success in creating incentives for delivery of more cost-effective approaches to medical care. Medicare might benefit from adopting these innovations. On the other hand, Medicare had lower rates of growth in

the 1980s as a result of strategies such as paying discounted fees to doctors and hospitals. These initiatives are only now being adopted in the private sector. In any case, it is important that comparisons be made on a per capita basis so that they do not reflect changes in the number of people insured. During the 1990s, the number of Medicare beneficiaries has been growing at 1 percent to 2 percent annually. By contrast, between 1988 and 1993, the number of people with employer-provided health insurance dropped by almost 6 percent.

I would also point out that it is unclear whether private sector spending has permanently slowed. Over short periods, health spending is quite volatile so it will be some time before it is clear whether this is the beginning of a long-term trend.

Opening up the Medicare program to more innovative methods of service delivery and payment than permitted under current law may result in a better match between program offerings and consumer preferences. Although Medicare beneficiaries have had the option of selecting managed-care plans for more than a decade, this option has not been uniformly available around the country and has been chosen by only a small percentage of beneficiaries nationally.

Until recently, the only private health plans available to Medicare beneficiaries were health maintenance organizations (HMOs). Most are paid under a full-risk contract, while a few use cost-based contracts (Table 1). Enrollment in risk-contracting plans has more than doubled in the past four years, but still accounted for only 8.8 percent of beneficiaries in 1995. Combined enrollment in risk and cost plans was 10.7 percent. Enrollment growth seems to have resulted from both rising interest among newly eligible beneficiaries and even faster increases for those who have been in Medicare for a year or more.

Table 1. Enrollment Rates for Medicare Risk-Contract and Cost-Contract Plans, 1991- 1995 (percentage)

Type of Plan	1991	1992	1993	1994	1995
Risk-Contract Plans	3.8%	4.4%	5.3%	6.6%	8.8%
Cost-Contract Plans	2.1	2.2	2.4	2.1	1.9
Total	5.9	6.6	7.7	8.7	10.7

SOURCE: Physician Payment Review Commission analysis of year-end enrollments for each year from the Managed Care Contract Reports published by the Office of Managed Care, Health Care Financing Administration.

Despite Medicare beneficiaries' growing interest in managed-care options, many of the new delivery arrangements now proliferating in the private sector have not been introduced into the Medicare program. While there is broad agreement about the benefits of expanding choices, there are substantial differences of opinion about the design of such a system. In part, these differences have arisen over how the private sector experience should be adapted to the unique structure of the Medicare program and the populations it covers.

There are also conflicting views about what Medicare can learn from the experiences of aggressive private purchasers. Because of its size, Medicare has substantial market power. If given the ability to act as an aggressive purchaser, Medicare has considerable potential to gain savings for the program, improve plan performance on behalf of beneficiaries, and influence changes in the delivery of medical care systemwide. This potential is threatening, however, to those who fear that Medicare might take the health system in the wrong direction.

Restructuring Medicare

Setting Capitation Payments. One of the key elements of Medicare restructuring proposals has been the design of a payment method for private health plans contracting with Medicare. Currently, Medicare risk-contracting plans are paid on a capitated basis, using a method based on adjusted average per capita costs (AAPCCs) in the Medicare fee-for-service program. Inadequacies in this methodology have contributed to uneven participation by health plans and beneficiaries across the country.

As you know, the existing AAPCC-based rates have a number of shortcomings: wide geographic variation in payments, volatility over time, inclusion of medical education and disproportionate share hospital payments that may not reflect use of these providers by plans, exclusion of certain expenditures such as for care provided by the Department of

Veterans Affairs, and limits on Medicare's ability to recapture cost savings achieved by participating health plans. In addition, the current risk adjustment of AAPCC-based payments captures only a small fraction of differences in enrollees' health care costs.

Variation in the AAPCC rates at the county level reflect local differences in both provider input prices (for example, costs of wages and supplies) and per capita service use patterns (the volume and intensity of care) in Medicare's fee-for-service program. In Table 2, the variation in AAPCC rates is shown as well as the variation in those rates after adjusting for differences in input prices across counties. The 1995 AAPCC rates ranged from a low of $177 per month to a high of $679, while the input price-adjusted rates ranged only from $324 to $530.

Table 2. Average Medicare Risk-Plan Payment Rates, Payment Volatility, and Enrollment Rates, by Urban and Rural Location, 1995

	AAPCC Rate (standard deviation)	Input-Price-Adjusted Rate (standard deviation)	Payment Volatility*	Enrollment Rate
All Counties	$402 (92)	$402 (46)	2.2%	7.3%
Urban Counties	428 (87)	418 (42)	2.1	9.4
Central urban	499 (83)	441 (40)	1.8	16.8
Other urban	393 (64)	406 (37)	2.2	5.8
Rural Counties	323 (50)	357 (20)	2.9	0.6
Urban fringe	330 (51)	357 (18)	2.7	0.7
Other rural	317 (48)	354 (21)	3.1	0.5

SOURCE: Physician Payment Review Commission analysis of Medicare AAPCC payment rates for 1991 through 1995 and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

* Payment volatility is measured as the annual average magnitude of change (higher or lower) in a county's payment index for 1991 through 1995 as a percentage of its five-year average index for that time period. The payment index is the ratio of the county's AAPCC rate to the national average rate per beneficiary.

Table 2 also presents a measure of payment volatility. These changes result from fluctuations in service use patterns and tend to be larger for areas with small Medicare populations. Health plans serving counties with volatile rates face greater uncertainty regarding payment rates for future years.

Several methods -- blended rates, payment floors or ceilings, and differential updates -- have been considered to reduce geographic variation in rates because of local service use patterns while allowing for variation in input prices faced by plans. Volatility could be reduced in a variety of ways as well.

The Commission's report analyzes several of the legislative proposals to address problems with the AAPCC methodology. In general, these proposals would reduce geographic variation in capitation rates moderately, primarily by raising very low rates. They also would reduce payment rate volatility by uncoupling capitation rates from Medicare fee-for-service spending.

It is the Commission's view that mechanisms will be necessary to monitor the effect of any change in the capitated payment method. For example, will lower-than- average rate increases in areas with currently high rates lead to benefit reductions by plans and disenrollments? Will larger-than-average rate increases attract health plan participation in small markets? Also of interest is how differences between capitation rates and fee-for-service per capita costs within local markets affect the choices available to beneficiaries, their enrollment decisions, and resulting Medicare costs.

Facilitating Beneficiary Choice. Several other issues demand attention when designing a system offering multiple choices to Medicare beneficiaries. Among these, risk selection, which I will discuss later, is of critical importance. Other key policy issues considered by the Commission include the number and types of plans that will be available, whether beneficiaries will have the option to enroll at any point during the year (as under current law) or only during an open season period, the types of information needed to support the choice process, and how quality of care and plan performance might be assessed.

The Commission's report offers some guidance on these issues, some of which were addressed in the congressional conference agreement. For example, one key issue has been the design of a more structured enrollment process. Last year, the Commission recommended that coordinated open enrollment was necessary to ensure that beneficiaries have full comparative information on their options. Implementing such a policy raises questions about the timing of open enrollment for plans and the length of time beneficiaries must stay enrolled.

If the Congress chooses to eliminate the current option giving beneficiaries the right to disenroll at any time, it is the Commission's view that certain protections for beneficiaries should be adopted. We recommend, for example, that the current policy of retroactive disenrollment should be available to beneficiaries who fail to understand the consequences of their choice of a private plan option. Moreover, if there is an annual lock-in requirement for beneficiaries and if a plan makes a major change in its network of providers during the year, beneficiaries should have the right to disenroll before year-end or to purchase services on a special point-of-service basis for the rest of the year. The exact circumstances under which such a policy would be invoked should be specified in regulations.

Information plays a critical role in beneficiaries' decisionmaking about plans. The Commission has considered what beneficiaries need to know about their options and the importance of this information to an effective choice-based program. Several key steps still need to be addressed, including creating materials responsive to beneficiary needs, developing effective dissemination methods, and providing enough resources to accomplish these goals.

The Commission has also explored the role of marketing rules in promoting informed choice and the working of a competitive market. Current Medicare policy permits plans to distribute information about plan features to beneficiaries in their service area. Continuation of several rules that have protected beneficiaries in the marketing process will be important if the array of plan options is broadened. To this end, the Commission has recommended that explicit marketing provisions included in current regulations be incorporated in any new regulations developed for private health plans participating in Medicare. These should include prohibitions on discriminatory marketing practices, misrepresentation of the Medicare program or the plan, door-to-door solicitation, and the giving of gifts or payment to prospective enrollees.

Risk Selection and Risk Adjustment. One of the most critical impediments to expanding Medicare choices is the potential for some plans to attract beneficiaries with low expected health care costs (referred to as favorable selection), while others attract those with complex medical problems and high costs (referred to as adverse selection). Although Medicare's per capita payment should be adjusted to reflect this risk selection, current risk adjustment approaches capture relatively little of any biased selection across plans.

Risk selection raises at least three problems for Medicare. First, costs increase if Medicare pays managed-care plans more than it would have cost to treat the same enrollees in fee for service. Second, inadequate risk adjustment hampers competition. That is, a poorly performing health plan may survive if it attracts low-cost beneficiaries, while a good plan may struggle if inadequately compensated for high-cost patients. Finally, inadequate risk adjustment of capitated payments may raise barriers to care for beneficiaries with high-cost conditions.

Numerous published studies have shown that beneficiaries who joined HMOs in the 1980s tended to have below-average costs in the period prior to enrollment. The Commission's analysis of more recent data shows that this is still true in the 1990s. New HMO enrollees' pre-enrollment costs are 20 percent to 40 percent below average, while those who disenroll from HMOs tend to have extremely high costs. Findings based on pre-enrollment and post-disenrollment utilization should be interpreted with caution, however, because neither new enrollees nor new disenrollees are typical of the average HMO enrollee. Hospitalization and mortality rates for new enrollees increase significantly during HMO enrollment (even after adjusting for the aging of the population), a phenomenon typically termed "regression toward the mean." The Commission plans to explore these results and their implications for risk-adjusting payments to managed-care plans.

In our report, we also note the progress made toward identifying those techniques that could be used to improve the current risk adjustment of Medicare payments to plans. For example, the Health Care Financing Administration (HCFA) has developed diagnosis-based risk

adjusters that offer a significant improvement over current techniques. Alternatively, methods that would pay plans partly on a capitation basis and partly on a fee-for-service basis would also reduce over- and underpayments due to selection. As this work proceeds, data requirements and the need for testing and validation must be addressed.

Medical Savings Accounts for Medicare Beneficiaries. Risk selection issues also anse in considering whether to offer medical savings accounts to Medicare beneficiaries. Medicare MSA options appear more likely than others to attract significant favorable selection. Beneficiaries who expect to spend little on health care in the coming year may disproportionately find MSAs financially attractive because they could keep more of the money deposited into the medical savings account. Conversely, those who expected high expenditures might find MSAs unattractive because it would be cheaper to buy Medigap insurance than to spend up to a large deductible. As a result, policies must be carefully considered to protect the Medicare program from increased expenditures due to selection.

To address these concerns, the Commission recommends that the enrollment and disenrollment rules of Medicare medical savings account plans be structured to reduce the potential for risk selection. Examples of restructured rules include a minimum enrollment period of several years in a Medicare MSA or requiring beneficiaries to announce their disenrollment from an MSA one or more years in advance. Moreover, if a Medicare MSA option is adopted, the Congress should require studies of selection into MSA plans both to determine what effect, if any, selection has on total program outlays and to identify a way to compensate for any selection that occurs.

Other elements of the design of a Medicare MSA option might also necessitate explicit policy decisions by the Congress. First, Medicare MSAs are typically envisioned in a traditional fee-for-service environment, but managed-care plans or other entities may be capable of offering them. If a Medicare MSA option is adopted, the Commission suggests there be no undue legal restriction of their ability to offer this product, and that federal laws limiting deductibles and copayments or mandating benefits richer than the ones offered by Medicare be waived for managed-care plans' Medicare MSA products. In addition, state laws should be preempted when they conflict with this provision of federal law.

Finally, there are issues regarding Medicare beneficiaries' ability to meet their financial obligations under an MSA option, particularly those with low-incomes. Of concern to the Commission is the possibility of access problems if providers become less willing to treat beneficiaries without a guaranteed source of payment. Medicare MSAs also raise important coordination-of-benefits issues for beneficiaries entitled to Medicaid or other tax-funded health care. Thus, any Medicare MSA proposal should be structured to reduce the potential for adverse effects on low-income beneficiaries, on providers who disproportionately serve them, and on state Medicaid programs.

Strengthening the Fee-For-Service Program

The Commission's 1996 annual report also devotes a number of chapters to issues affecting Medicare's fee-for-service program. In part, these reflect the Commission's ongoing responsibility to monitor the implementation of physician payment reform. But they also focus on improving program performance.

Physician Payment under Medicare Fee for Service. As the transition to payment under the Medicare Fee Schedule nears completion, there is much good news to report. Access to care appears to be good for most beneficiaries. Physician participation and acceptance of assignment continue to grow with 95 percent of claims now accepted on assignment. Balance billing has declined dramatically. And despite reductions in some Medicare payment rates, beneficiaries' use of almost all services continues to grow (Table 3).

In addition, Medicare does not appear to be pricing itself out of the market for physicians' services. Medicare now pays, on average, 71 percent of private rates. This gap is narrower than in 1992 when Medicare paid 61 percent due to higher Medicare payment rate updates and lower inflation in the private sector.

Despite these successes, there are still areas of concern. For example, the distribution of physician payment has changed less under the fee schedule than originally anticipated. Gains for evaluation and management services have not been as large as expected because of use of separate conversion factors for surgical services, primary care services, and all other services. In addition, the Commission remains concerned that access problems persist

for vulnerable groups such as African Americans, and those living in urban poverty areas, and urban Health Professional Shortage Areas.

Table 3. Change in Medicare Payment and Volume, by Type of Service, Location, and Specialty, 1994-1995 (percentage)

Type of Service, Location, and Specialty	Medicare Payment per Service	Volume and Intensity per Physician	Medicare Payment per Physician[a]	Medicare Revenue per Physician[b]	Percentage of 1995 Medicare Payments
All Services	3.8%	4.1%	8.0%	7.9%	100.0%
Evaluation and Management Services					
Primary care	9.0	3.1	12.4	12.2	20.0
Other	6.7	0.3	6.9	6.9	16.5
Surgical Services	5.0	4.5	9.7	9.6	23.2
Other Nonsurgical Services	-0.4	5.9	5.4	5.4	40.3
Location					
Metropolitan areas					
>1 million	3.5	2.8	6.4	6.4	53.0
<1 million	3.8	5.6	9.6	9.5	34.5
Rural counties					
>25,000	4.8	7.1	12.2	12.1	10.1
<25,000	6.6	1.4	8.1	7.9	2.5
Specialty					
Cardiology	-1.4	3.5	2.1	2.0	8.4
Family/general practice	7.5	-0.1	7.4	7.2	10.1
Gastroenterology	1.2	-2.6	-1.5	-1.6	2.9
Internal medicine	5.0	5.1	10.4	10.2	16.7
Other medical specialties	5.7	8.0	14.2	14.2	8.2
General surgery	6.1	7.5	14.1	14.0	5.6
Dermatology	7.8	4.2	12.3	12.1	2.1
Ophthalmology	1.1	2.2	3.4	3.3	9.0
Orthopedic surgery	5.7	3.8	9.7	9.5	4.8
Thoracic surgery	5.2	4.2	9.6	9.5	2.4
Urology	5.9	5.8	12.0	11.9	4.1
Other surgical	5.8	2.4	8.3	8.2	3.2
Radiology	1.6	-1.5	0.1	0.0	7.9
Pathology	-1.6	2.3	0.7	0.6	1.2
Other	2.5	4.8	7.4	7.5	13.4

SOURCE: Physician Payment Review Commission analysis of 1994-1995 Medicare claims, 5 percent sample of beneficiaries; American Medical Association 1994 and 1996.

[a] Medicare payments are allowed charges.

[b] Medicare revenue is allowed charges on assigned claims and submitted charges on unassigned claims not in excess of charge limits.

It is also important to note that although the fee schedule transition period is now over, the fee schedule, physician payment patterns and policies will continue to evolve as a result of changes in relative values, the conversion factors, and geographic adjustment factors (Table 4). Policy developments on the horizon include implementation of resource-based practice expense relative values in 1998, completion of the five-year review of work relative values, and improvements in the definition of payment areas.

Of these, Commission is particularly concerned about activities under way to develop resource-based practice expense relative values. These include HCFA's ability to develop values in time for implementation in 1998, the difficulty in collecting reliable data, and the lack of a clear plan for establishing values from the various research projects envisioned as part of the process. As a result, it recommends that the Congress should revise current law so that resource-based practice expense relative values will be phased in over a three-year period beginning in 1998. In addition, it should direct HCFA to develop a process and timetable for refinement of resource-based practice expense relative values, which should be announced when proposed values are released for public comment.

Table 4. Effect of Policy Changes on Fee Schedule Payments, 1994-1995 (percentage)

Type of Service, Location, and Specialty	Total Change in Medicare Payment per Service	Change Due to: Relative Value Unit Changes	Geographic Adjustment Factor Changes	Conversion Factor Updates	Transition to Fee Schedule
All Services	3.8%	-1.9%	0.1%	7.5%	-1.9%
Evaluation and Management Services					
Primary care	9.0	-1.0	0.0	7.9	2.1
Other	6.7	-1.0	0.0	5.2	2.5
Surgical Services	5.0	-3.7	0.0	12.2	-3.5
Other Nonsurgical Services	-0.4	-1.6	0.1	5.2	-4.1
Location					
Metropolitan areas					
>1 million	3.5	-1.8	0.1	7.4	-2.2
<1 million	3.8	-2.0	0.1	7.7	-2.0
Rural counties					
>25,000	4.8	-1.9	-0.2	7.7	-0.8
<25,000	6.6	-1.4	-0.3	7.4	0.9
Specialty					
Cardiology	-1.4	-2.6	0.0	5.7	-4.5
Family/general practice	7.5	-1.1	-0.1	7.2	1.5
Gastroenterology	1.2	-1.9	0.1	5.7	-2.7
Internal medicine	5.0	-1.1	0.1	6.4	-0.4
Other medical	5.7	-1.0	0.1	5.6	1.0
General surgery	6.1	-1.4	0.0	9.9	-2.4
Dermatology	7.8	-1.0	0.1	10.5	-1.8
Ophthalmology	1.1	-5.7	0.1	10.0	-3.3
Orthopedic surgery	5.7	-3.0	0.0	10.5	-1.8
Thoracic surgery	5.2	-1.4	0.0	11.2	-4.6
Urology	5.9	-1.2	0.1	10.1	-3.1
Other surgical	5.8	-2.0	0.1	10.0	-2.3
Radiology	1.6	-1.0	0.0	5.3	-4.8
Pathology	-1.6	-1.6	0.1	5.2	-5.3
Other	2.5	-0.8	0.1	7.3	-4.1

SOURCE: Physician Payment Review Commission analysis of 1994-1995 claims, 5 percent sample of beneficiaries.

NOTE: Changes due to the transition to fee-schedule based payments are calculated as the difference between total payment changes and the sum of changes attributable to relative value changes, geographic adjustment factor changes, and conversion factor updates.

The Commission is also concerned how payment policy changes may affect the fee schedule's integrity. Whenever relative values are changed, the relationship of values across codes and the components of the fee schedule (physician work, practice expense and malpractice expense) may be changed. Moreover, there is some evidence to suggest that revenue shares originally allocated to the three components of the fee schedule are changing. To address these concerns, the Commission recommends that:

- Implementation of any changes to work relative values as a result of the current five-year review should be budget neutral with respect to work values and should not affect practice expense and malpractice expense relative values.
- HCFA should continue to achieve overall budget neutrality by adjusting the conversion factors as it did for 1996, rather than by adjusting relative values, as it has in previous years.
- The relationship between the three components of the fee schedule should be rebased annually to reflect the three-year moving average of physician revenue shares as reported in national surveys.

Improving the Volume Performance Standard System. The report also analyses the design of the Sustainable Growth Rate system, proposed by the Congress and the Administration, as an alternative to the current system of Volume Performance Standards (VPS). As you know, the VPS curbs Medicare spending for physicians' services by linking

payment levels to the growth in the volume and intensity of services. The system uses performance standards to set target rates of expenditure growth, and annually updates conversion factors depending on whether expenditure growth met the targets two years earlier.

While the VPS has constrained spending for physicians' services, several methodological flaws prevent it from working as intended. First, limitations in the formula now used to set updates will result in substantial reductions in the conversion factor over the next five years. Second, the existence of three performance standards is introducing serious distortions in the patterns of relative payment, the very problem the Medicare Fee Schedule was intended to correct (Table 5).

Table 5. Conversion Factors, by Category of Service, 1992-1996 (dollars)

Category of Service	1992	1993	1994	1995	1996
All Services	$31.00	-	-	-	-
Surgical Services	-	$31.96	-	-	-
Nonsurgical Services	-	31.25	-	-	-
Surgical Services	-	-	$35.16	$39.45	$40.80*
Primary Care Services	-	-	33.72	36.38	35.42*
Other Nonsurgical Services	-	-	32.90	34.62	34.63*

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the *Federal Register.*

* These conversion factors include an additional 0.36 percent reduction due to a budget-neutrality adjustment. This adjustment offsets increases in spending from changes to the relative value units and other payment policy changes for 1996.

The proposed Sustainable Growth Rate system incorporates many of the Commission's previous recommendations to correct these limitations. It would establish a single conversion factor that would remove the current distortion created by multiple conversion factors. In addition, target rates of growth would be linked to growth in per capita gross domestic product instead of the five-year historical trend for volume and intensity growth of physicians' services currently used under the VPS system. Conversion factor updates would be based on comparisons of total actual versus allowed spending accrued since a base year, replacing the year-to-year comparisons and two-year delay in the current system.

Although these changes correct many of the limitations of the VPS system, the Commission's report points out two limitations inherent in any administered price system. While the proposed system establishes more realistic targets, no such system can set targets that reflect appropriate levels of care or changes in the medical marketplace. Also, limits on the size of annual conversion factor updates are necessary for constraining volatility in annual adjustments. Otherwise, the updates would reflect year-to-year fluctuations in volume and intensity growth, as well as the changes necessary to recoup any excess or surplus spending in a single year. An additional limitation of both the VPS and the proposed systems, which results from incorporating projection errors into the calculation of conversion factor updates, could be readily corrected. To address these concerns, the Commission recommends that any revision to the Volume Performance Standard system should annually correct for any projection errors in the target growth rate from prior years.

Because the VPS remains in law, the Commission will continue to make annual recommendations regarding fee updates and performance standards as mandated by the Congress. Our 1996 VPS report will be discussed at the Commission's meeting later this week. It will be transmitted to you to meet the May 15 deadline required under the Omnibus Budget Reconciliation Act of 1989.

Managing Medicare's Fee-for-Service Program. A new area of work represented in this year's report is exploration of techniques that Medicare and private indemnity payers have been introducing to manage delivery of health care on a fee-for-service basis. To better understand the state of the art, the Commission sponsored a survey of 10 innovative Blue Cross Blue Shield plans. Four approaches were used by all or almost all the plans surveyed: *case management, practice guidelines, rebundling of services, and provider profiling.* Providing financial incentives to physicians was also considered important in reducing costs.

Many of Medicare's initiatives mirror those in the private sector. For example, various aspects of Medicare's provider profiling techniques and activities appear comparable to those of private payers. Profiling activities could be strengthened by comparing profiles with practice guidelines; this would make it possible to detect deviation from appropriate care rather than from common practice patterns. Another initiative is HCFA's recent implementation of changes to enhance its ability to detect the use of inappropriate billing codes. Medicare is also experimenting with case management through demonstrations and is investigating methods of paying for case management by using bundled payments.

It is important to recognize the differences between the Medicare fee-for-service program and private payers that may bear on the effectiveness of management techniques, and in some cases, the feasibility of implementation. As a public program, Medicare's rules and authorizing legislation require that it operate differently from private payers. For example, current law permits all providers to participate in the program and that beneficiaries be guaranteed freedom to choose providers. This provision may complicate the implementation of management strategies that offer financial incentives to modify provider or patient behavior. Moreover, increased flexibility may be necessary in Medicare coverage and payment policies to accommodate management techniques such as case management.

In addition to continuing with the initiatives that are easily applied to Medicare, the Commission recommends that HCFA should explore ways that Medicare can make use of other cost-effectiveness techniques that appear promising yet conflict with current policies. As a first step, the Commission recommends that HCFA work more intensively with its Part B carriers and Part A fiscal intermediaries to implement the best private-sector practices for managing cost and quality of care within a fee-for-service context. This could include a formal request for proposals from carriers and intermedianes to test promising methods and increased financial flexibility to implement new management techniques.

Additional Issues

Several issues included in the 1996 Annual Report have implications for both Medicare's fee-for-service and managed-care programs.

The Failsafe Budget Mechanism. The failsafe budget mechanism included in the congressional conference agreement relies on assumptions about the rate of growth in managed-care enrollment and spending growth in fee for service. While the Commission appreciates the need to slow the rate of growth in Medicare expenditures, several methodological limitations may keep the failsafe budget mechanism that was proposed from operating as intended. First, the failsafe only lowers payment levels and makes no provisions for increasing payment. Because payments would be dropped permanently to meet any anticipated excess spending, the mechanism would take larger reductions than needed in order to reach budget goals. In addition, payment reductions under the failsafe budget mechanism may reflect fluctuations in annual spending growth and errors in projections of spending. While the mechanism corrects for overspending that may have occurred two years earlier, it does not adjust for projections that were too low. The mechanism could be improved to better limit the effects on annual variation by revising the methodology so that savings in one year offset spending excesses in other years. This mechanism could also adjust for all errors in projections of spending.

If a failsafe budget mechanism is adopted, the Commission recommends that it be modified in three ways. Any payment reductions should apply for one year only, and then payment levels should be returned to the level they would have achieved had the failsafe budget mechanism not been triggered. The mechanism should also be based on comparisons of total actual spending and total allowed spending accrued since a base year. In addition, it should correct annually for any projection errors regardless of whether these errors were too high or too low.

Secondary Insurance for Medicare Beneficiaries. Another issue affecting both Medicare fee for service and managed care is the impact of secondary insurance coverage on Medicare expenditures and the types of choices available to Medicare beneficiaries. As this issue was new to the Commission this year, we began our work in this area by developing background material, identifying the pertinent policy issues, and laying out potential options. Roughly three-quarters of Medicare beneficiaries have some private health insurance in addition to their Medicare coverage. Although these arrangements provide valuable financial

protection to Medicare beneficiaries, they also have implications for the Medicare program. Higher utilization among Medicare beneficiaries with Medigap insurance translates directly into increased costs for Medicare. The Commission's analysis of the 1993 Medicare Current Beneficiary Survey confirms previous estimates that Medicare beneficiaries with first-dollar supplemental coverage have rates of service use from 25 percent to 33 percent higher than those for beneficiaries without supplemental coverage.

Medigap insurers and Medicare risk-contracting plans operate under different rules governing their premium rate-setting and underwriting practices. This raises two important issues: the appropriateness of applying different standards to the two types of insurance coverage, and the implications that these different pricing strategies have for beneficiary access to and beneficiary choice of supplemental coverage. The artificial barriers to choice raised by these different rating and underwriting standards will become even more critical if the Medicare program is restructured to broaden beneficiary choice.

Options for modifying current supplemental insurance fall into three general approaches: revising current policy, creating partial risk-sharing arrangements, or allowing or requiring insurers to assume full risk for both Medicare and supplemental benefits. The Commission is now planning work to examine the advantages and disadvantages of these approaches.

The Changing Labor Market for Physicians. Finally, the Commission's report takes a look at whether and how changes in the organization and financing of health care are affecting the labor market for physicians. Two types of change in the labor market have been assessed: whether there is evidence that increasing demand for primary care physicians is leading to changes in specialty mix, and if there is any indication that changes in the market have reduced the overall number of physicians being trained.

The Commission's review suggests that change is occurring, but that it is relatively modest. For example, generalists' incomes have exhibited small gains relative to those of specialists, and both the percentage of senior medical students expecting to be certified in generalist fields and match rates for generalist residencies are increasing somewhat. Overall growth in the number of residents has declined, with the most substantial decreases in specialist fields. Growth in the number of international medical graduates in training may overwhelm any changes made in response to market dynamics by graduates of U.S. medical schools. Because most data sources are national in scope, it is difficult to know whether change is more pronounced in the most competitive markets.

As you well know, restructuring the Medicare program encompasses a wide range of policy and technical issues. The Commission's 1996 annual report addresses a number of those issues to respond to the needs of the Congress. We look forward to working with this committee as it continues to consider changes in Medicare in the months ahead.

Chairman THOMAS. Thank you, Dr. Wilensky.

You mentioned this expense of relative values that HHS has to set up. How comfortable are you in their ability to meet the deadline? I believe it was January 1, 1998.

Ms. WILENSKY. We are uncomfortable, in short.

We think that to move to this payment in its entirety, January 1988 would be difficult, with probably unintended consequences. Therefore, we recommend a phase-in over a 3-year period.

Chairman THOMAS. So that is the primary reason you offer the transition period?

Ms. WILENSKY. It allows for HCFA to make some adjustments as it goes. We are concerned whether they will be ready at all in January 1998. Even if they claim to be ready, we think the potential for unintended consequences, if you go the full change, is too great.

Chairman THOMAS. I believe one of the common areas between the President's plan and our plan was movement toward a single conversion rate.

Ms. WILENSKY. Correct.

Chairman THOMAS. It might have been a year or two difference between the two.

Ms. WILENSKY. Correct.

Chairman THOMAS. How are your feelings about moving, whether a transition or implementation, while at the same time we are talking about moving toward a single conversion rate?

Ms. WILENSKY. It also will become complicated, and we think the implications of how you make that transition probably had enough attention paid to them. Not making a transition to a single conversion factor, though, is going to exacerbate the problems of undoing the relative value scale, which you are aware have been a concern of this Committee for several years.

Chairman THOMAS. The last hearing, as a matter of fact, was on graduate medical education, and I learned a number of interesting things. One of them was that apparently, there is a much better open line of communication between what the marketplace will take and what young people's interests are in terms of fields of medicine.

Have you folks looked at that, and do you believe that the marketplace exchange of information will be adequate to direct career match ups, or do you still think from our end of it, we ought to do some pushing and structuring regarding who gets funded?

Ms. WILENSKY. The answer is some of both. Let me explain. There does appear to be getting a message out that primary care will be more attractive than radiology for a variety of reasons in the future. There has been a substantial increase in the reported match rates for interns and residents in primary care over what had occurred in the last few years.

I think that word is going out, as well as the difficulty for residents in some highly specialized areas, such as radiology and anesthesiology, to find jobs.

There appears to be a very modest slowing of income growth and of bringing together in a very modest way the gap between primary care and specialty physicians. So I think that the word seems to be getting out, although it is interesting that applications to medical school remain at an all-time high, which may be as much a

statement about views of other areas as it is about the future of medicine.

I think because the Federal Government is spending a substantial amount of money in the area of graduate medical education that it can't ignore the effects that it has produced.

There appears to be something of an intermediate market that has developed at the institutional level because of the substantial amount of payments that are available. These may not have a lot to do with the final demand of physicians in certain areas. I also think we can't ignore the fact that several billions of dollars, $6 or $7 billion that go out in graduate medical education payments has an effect whether or not you intend it. Therefore, the issue of how much, why the Federal Government is making payments in this area at all, where you want to be and how you want to transition from the present program to where you ought to be in 5 years will remain very important.

Chairman THOMAS. One of the other things I would ask, and I want to make sure I say this correctly because I don't want anyone to misunderstand me, is that information that we received was that it appeared that foreign medical graduates were involved in the specialty areas at a higher rate. That may increase in the future. I just want to make sure that as we monitor where primary physicians and the specialties are coming from, if there is any signaling of an inordinate number of foreign medical graduates, it might be possible to look at several concerns and deal with them at one time if, in fact, there is a high propensity in that direction.

Ms. WILENSKY. This is certainly possible to alert you as to the choices that are being made by various groups.

Chairman THOMAS. Thank you very much.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you, and welcome, Dr. Wilensky.

Ms. WILENSKY. Thank you.

Mrs. JOHNSON. In your testimony, you recommend that in the capitation payment methodology for Medicare risk contracting plans, that we remove Medicare payments to providers for medical education costs from the capitation payments.

We did not go that far in our recent proposal because of our concern that premiums would not be high enough to command a basket of services that would be adequate for seniors, and not having the time to change the AAPCC technology, we simply did not withdraw the medical education component from the capitated rate.

When you look at the challenge of revising AAPCC versus simply finding alternative sources of medical education dollars, what route do you recommend we go?

Ms. WILENSKY. I actually think because of the small number of seniors who are in capitation plans, your choice was a perfectly reasonable one, especially if you separate out the growth rate of the capitation plans from what goes on in fee-for-service. What you are really doing is locking in an 8- or 9-percent population factor that is in the AAPCC that has to do with medical education.

If you were to wait until the capitation plan represented 20 or 30 or 40 percent of the population, then having a differential which may or may not be correctly attributable to the plan that was real-

ly meant for graduate medical education would become far more serious.

By separating out, you took what was representing 8 or 9 percent of the Medicare population. You froze it at that level. It would become an increasingly smaller and smaller share of the capitation program. So, if you do something soon, I actually think what you propose doing was perfectly fine. It did not have a major effect, especially because you had set up a trust fund, but that doesn't mean if you had the time to develop a way to, first, extract and then, more importantly, decide how to distribute those graduate payments, that would be fine. I just don't think you did much damage at this point.

Mrs. JOHNSON. Because no legislation has been passed in this area, I am beginning to see in our medical centers the impact of the managed care deal, so to speak, and so we are already beginning to see a hemorrhaging of resources that are critical to the survival of these medical centers. Has any of your data begun to reflect that yet?

Ms. WILENSKY. The distribution, as you know, is not even. The 8 or 9 percent who choose capitation plans tend to be targeted in high-payment areas. So, in those areas, you will do a little more than just the 8 or 9 percent.

We have not seen any impact yet, and I think the reason is because both ProPAC and PPRC have indicated that the moneys going to the academic health centers, in fact, are substantially greater than one would justify strictly on the basis of what Medicare does to them for reasons that have to do with providing uncompensated care or other roles that these institutions play.

So I think, actually, that is not a problem to date. The longer you wait, the more it could become a problem.

Mrs. JOHNSON. I would hope that you would focus some of your resources on areas of the country, and of course, I am particularly familiar with the Northeast, where managed care has not been a big component in the market for seniors particularly, nor have HMOs. So the sudden influx of those and the pace at which now I think in the next year and 2 years, even 6 months and 1 year, people are going to be joining those plans, it seems to me it could create a problem for the medical centers of Boston and Connecticut, and perhaps, to some extent, New York. I am a little less familiar with that situation.

So I think we need to begin tracking that early, so that we can see what will be the consequence if we don't do anything.

Ms. WILENSKY. Yes, I agree, and we will do so.

It certainly could have an impact in those areas that have academic health centers and traditionally have not had very much in the way of managed care growth, and we will do that.

Mrs. JOHNSON. You won't have time to answer this, but I would appreciate your help in taking a look at the kinds of issues that Chris Shays raised in his testimony.

I have served on this Committee for many years, and frankly, we have been notably ineffective in many instances in getting at the kinds of problems that he describes. I would say that those kinds of problems are being brought to my attention far more frequently now than they have in the past, which reminds you that the pri-

vate sector is affecting the cost structure in the health industry, and our rates aren't changing. So, in many areas, we are increasingly overpaying. We need your help in better identifying these areas.

Ms. WILENSKY. Mrs. Johnson, let me conclude my answers to you by saying the issue that you had raised earlier with Dr. Newhouse struck me as going to the heart of something that I am sure this Committee will take up in the future. This has to do with the differences between defined benefits and defined contributions and to what extent can we assume that a defined contribution will leave you satisfied with the benefits that go with it.

This is probably one of the most important issues that the Commissions could provide some assistance with, and I am sure we would both be glad to do so, and to do so in a joint way if that would help.

Mrs. JOHNSON. That would be very helpful. I appreciate that. Thank you.

Chairman THOMAS. I thank the gentlewoman.

Given the sobering effect of the numbers, I think at least that discussion needs to go on to be able to look at the parameters.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you.

I am sorry I missed your presentation. I will try to outline a few questions I had based on the prepared testimony.

Just one of the issues that I have been concerned about and the PPRC recommendations touches on—on page 18 of the report under Recommendations—that the same core standards be applied to all private health plans participating in Medicare.

Ms. WILENSKY. Right.

Mr. STARK. Were you referring to the fact that some of the new organizations recommended in legislation have easier or different standards than others? It has been my assessment that we ought to come as close as we can to having universal standards where it is able to apply. Is that the point that you were getting at?

Ms. WILENSKY. Yes. What we tried to balance was the recognition that in different designs, precisely how you got someplace, might be forced to differ or might in common sense wish to differ, but the fundamental issues like solvency and protecting the seniors, those are issues that were as important for new plans as for old plans. Some might even say more important, but certainly as important.

Mr. STARK. The risks that a beneficiary would face, the limit of their liability, so that it is clearly defined to how much they might be at risk, is an issue that should apply, so that whichever plan you go into, you understand as a beneficiary what your contribution or risk might be.

Ms. WILENSKY. The answer is yes, to the extent the design was consistent. To some extent, in some of the designs, it allowed outside of the traditional barriers. In that case, we wanted to be sure that the seniors understood that if they chose a medical savings account, there may be higher prices that could be charged and, therefore, different liabilities. But it was extremely important, then, to be sure the information to the senior was as clear as we knew how

to make it; otherwise, within the Medicare benefit package, to keep the same standards.

Mr. STARK. A topic that we have heard a lot about is the medical savings account. Your analysis is interesting. If I read it correctly, you are saying that they are a good deal for anyone with less than $1,000 in medical expenses and that for each person who joins, it will cost Medicare about $2,400 a year more than would otherwise have been spent.

Do you want to lead me through that? I think I know the answer is why you say it is a good deal if you expect less than $1,000 in expenses. Go ahead. I will let you say it. I won't.

Ms. WILENSKY. Let me start by saying all of our analyses of medical savings accounts are by their nature highly speculative. We don't have anyplace to turn to, although PPRC has spent a lot of time looking at the issue of risk selection and trying to bring it up to date.

Our concern had been, in part, with a notion of a medical savings account that had an annual selection and, in part, with a particular construction that a medical savings account had in legislation, not necessarily any medical savings account that might be devised. Therefore, it was the staff's estimate that the current construction would have a risk selection problem associated with it, and therefore, it costs Medicare more if it maintained an annual selection.

Mr. STARK. Did the $1,000 relate to the fact that that is about what a Medigap policy that is fairly generous costs, or is that just a coincidence?

Ms. WILENSKY. I don't think that it related to the Medigap, but I will check that with the analyst who did the estimate.

Mr. STARK. Let me try this on you as an economist. Wouldn't it make sense as a businessperson? Let's do this a minute. You are running a business and you have got 100 employees. You are going to put them in a medical savings account. Let's say it is $1,000, just to pick the number, that you are going to give each employee, and they can either spend it until their policy kicks in, or if they are not sick, they can save it. The employer has got to pay $100,000 for his 100 employees.

Let's assume for 1 minute that the standard idea that only 20 percent of the population ever uses their health insurance in any 1 year and 80 percent don't need it or somewhere in there. Why wouldn't the employer say wait 1 minute, I'll buy the high deductible, but I will only pay the copays for people who get sick? The employer is not giving these people something to save in their account, but the employer is only putting $20,000 out if you assume, in fact, that 20 percent will use their insurance. He gets the same deduction. The people who get the $1,000 actually have to run it through their tax, but that might not bother them if they were sick and needed the money.

As a small business person or a medium sized business person, why wouldn't that be a more attractive way to go on the theory that the remaining $80,000, if you followed the MSA plan, is almost just a gift, although it is randomly distributed? So, if you really wanted to be an efficient employer and use that savings even for a better policy, why wouldn't that be a more economic approach?

Ms. WILENSKY. That is a fairly complicated example for me to think about, but it strikes me that one of the problems that you raise is that if you have the employer paying the copay, you now have no reason on the part of the insured to care about what is being sent.

Mr. STARK. On the other hand, you take away the incentive for people, maybe, not to get treatment because they want to keep the money in the savings account, which people have suggested is one of the downsides. People might not go for that initial doctor's appointment when they ought to.

Ms. WILENSKY. I have a section 125 provision at Project Hope which lets me put aside money that is not covered by my insurance. So, in some ways, that aspect of a medical savings account is very common if it is not a big employer, and I have that ability.

It has a terribly perverse aspect. It is called use or lose. At the end of the year, any money that I have set aside, if I haven't spent it, it just goes away.

Last year, I made the mistake, and I had $250 that I didn't spend. I am sure this year that I will go to visit my ophthalmologist or my dentist or something, so I am not going to let that happen.

Chairman THOMAS. You are beginning to sound like a bureaucrat again.

Ms. WILENSKY. It was my money, and I was going to do the use-it-or-lose-it, and I didn't want to lose it anymore. It is really taking an idea that actually has been around for years and saying that the way it is now is very perverse, and we let people roll it into the future, so that they can keep it aside in case they have a catastrophic illness. It is taking something that we actually are quite familiar with and saying we want to make it better.

So, while there are concerns about risk selection that are very real, and I don't want to downplay them, I think that we sometimes talk about medical savings accounts as though they were an animal with four heads. Whereas, in fact, the section 125 is really a medical savings account that many of us have access to.

Mr. STARK. Thank you.

Chairman THOMAS. A medical savings account with term limits.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

Dr. Wilensky, I think you answered the gentleman from California's question quite well regarding medical savings accounts, but in fact, your report only looks at MSAs in the context of Medicare. Is that right?

Ms. WILENSKY. Yes. That is what the Commission's charge is, and that is the only thing we looked at.

Mr. MCCRERY. In your report, you suggest a number of safeguards that might be enacted by the Congress in order to reduce the risk of adverse selection. Is that correct?

Ms. WILENSKY. That is correct.

Mr. MCCRERY. Based on your general knowledge of the health care system, is the potential problem of adverse selection more in the Medicare population than it is in the rest of the population?

Ms. WILENSKY. That is actually a hard question. The Medicare population uses a lot of health care. So, if you miss, it can cost you

more money, but actually, the concentration of spending is greater in the under 65 population, in part, for that very reason.

Mr. MCCRERY. In a relative sense.

Ms. WILENSKY. Right, in a relative sense. In a relative sense, risk selection may be even greater in the under 65 population. In absolute dollars, the impact that not adjusting for risk selection could have is high just because so much money is spent on older people. It is something we have to acknowledge.

Mr. MCCRERY. I am not sure I follow you. Let me rephrase my question, and then you can go on. It seems to me that in the Medicare population, you are going to have a higher percentage of beneficiaries knowing that they have adverse health conditions compared to the below 65 age population.

Ms. WILENSKY. Right.

Mr. MCCRERY. So it doesn't compute up here right now that the problem could be worse, even in a relative sense, or especially in a relative sense in the under 65 population.

Ms. WILENSKY. The concentration of spending in the under 65 is even greater. That is slightly a smaller percent that account for an even larger number of dollars in the under 65.

If you don't make adjustments for where that concentration is, then it could cause you in a relative sense even greater difficulty in the under 65.

The over 65 has high averages. It is slightly less concentrated, and the reason is because lots of people have some health care needs. But please understand, risk selection ought not to be regarded as an excuse for not doing things. We need to look at risk selection as something that we have got to fix so we can give people choices.

Mr. MCCRERY. I understand we would all like to fix the risk selection problem. Nobody has figured out a way to do it yet.

Again, if the bad result from adverse risk selection is higher premiums for everybody else——

Ms. WILENSKY. Right. It is a bigger problem in the Medicare population.

Mr. MCCRERY. That is what I am trying to get at.

Ms. WILENSKY. Yes. In dollars, it will have a bigger impact in the Medicare population.

Mr. MCCRERY. So, if that is the problem, if we want to avoid that problem, then we would more likely not provide MSAs in the Medicare population than not provide it in the general population of the under 65 population because, then, in that population, the insurance system has a much broader universe of people to spread that risk to. So that is what I was getting at.

Ms. WILENSKY. Yes. I think that that is correct.

I think by having a slightly longer decision period as one of the possible ways, it is possible to do this for the Medicare population as well. I didn't want you to drop that idea for the Medicare population because I think it is something that you can try to respond to imperfectly by, for example, having a slightly longer selection period.

Mr. MCCRERY. I don't want to drop the idea of MSAs for the Medicare population. I think you have given us some very constructive suggestions to maybe make offering MSAs to the Medicare

population. Since the gentleman from California got into MSAs in the general population, I wanted to make it clear that the risk involved, if we think the risk is increasing what everybody else pays, is much less with the under 65 population than it is for the other Medicare beneficiaries.

Ms. WILENSKY. Right. In the dollar amount, it definitely is much less.

Mr. MCCRERY. Thank you.

Mrs. JOHNSON [presiding]. Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

Gail, it is very nice to have you in the Committee.

Ms. WILENSKY. Thank you.

Mr. CARDIN. I was very pleased to see in the Commission's report the recommendation that a prudent layperson's perspective should be considered as one of the factors in determining when a health plan that participates in Medicare should pay for initial screening and stabilization, if necessary, in an emergency.

Ms. WILENSKY. That is correct.

Mr. CARDIN. I have filed that legislation here in Congress. With the expectation that there will be more managed care options available to our seniors within Medicare, it seems to me that it becomes even more important for us to move toward the reasonable layperson standard for emergency care.

I was curious what precipitated this recommendation and whether you are experiencing more complaints within the Medicare population.

Ms. WILENSKY. This is an issue that PPRC has taken up before. As we open up choice, we do expect more of the seniors to go into traditional managed care, as well as any of the new varieties; that any of our concerns that have been in the past get moved forward. It was why we were very specific about having some of the marketing safeguards that have been in past legislation be moved into the future legislation. I am not sure if there has been an increase, but it is an issue we have raised in the past.

We think the growth of managed care makes it even more important in the future because of the larger numbers of who would be at risk.

Mr. CARDIN. I applaud you for that. We are finding that the States that have adopted this standard, including my own State of Maryland, that it has worked rather successfully. We have very few complaints from health care plans. It seems to me that this is one area where there is a developing national consensus that we should use that standard within Medicare and develop it nationally as well. So I look forward to working with you in that regard, and hopefully, we can implement that recommendation.

If I might, let me move on to a second area where you talk about giving the option to beneficiaries to disenroll at any time and then having the ability to go into a plan that would offer at least a point-of-service option or choice to the beneficiary.

My question is, should we be considering requiring all the managed care programs that want to participate in Medicare, to offer the beneficiaries at least a point-of-service option?

Ms. WILENSKY. This is not an issue that the Commission raised.

My personal view is we should not put such a requirement in place because I think that you ought to allow plans that want to offer only a traditional staff or group model HMO and to price accordingly between benefits and whatever premium charges they make, to have that as an option. The only hesitation I would have is if in any marketplace it was observed that there were no point-of-service options available. Then I think you could decide whether or not there ought to be a role of government to make sure that there were some there.

I think to require that is just not the best way to make plans available to seniors. It will cost plans money they may or may not be able to capture, all of the costs associated with a point-of-service. So I would not do that unless it was clear that there were markets where you just didn't develop point-of-service.

Mr. CARDIN. There are several ways you could implement it. My concern is that if you are going to permit disenrollment, you are going to then find that a plan that does not offer the point-of-service option may be at an advantage of trying to get some of its higher risks out of their plans into other plans that offer the point-of-service.

Whereas, if the plan offers the choice of the point-of-service option, they are staying within the same plan. It seems to me it may promote more competition rather than less if all HMOs have to operate under the same standards.

A good HMO, with its marketing strategy, is not afraid of offering the point-of-service, even if it doesn't want its beneficiaries or enrollees to go out of network because they will have satisfaction within the plan. But, if they are permitted to offer without point-of-service where someone else has the point-of-service, it may not be fair competition.

Ms. WILENSKY. I have two points. One is, I actually think the plans that offer point-of-service will, in fact, be in a better place in the marketplace because I think that is actually what people are more likely to choose. So I think that plan that didn't do that would find themselves at a competitive disadvantage.

I wanted to be sure it was clear that what we were saying is that while, in general, annual enrollment was a model that the Congress was at least considering and we had some comment about it, we thought it was important that if an event occurred during the year that changed the nature of a plan that, in that case, if it was significant, enrollees be allowed to make a different choice. We were not taking a position that, in general, people ought to be able to disenroll in 30 days as they do now. That is a decision that Congress has to make as to whether or not it wants to proceed.

Even if you went to an annual choice, as is prevalent in the private sector, it will be important to have an allowance if a plan changes in a major way which needed to be defined in regulation as to what constituted major. At that point, you would need to allow individuals to make a second-round choice.

Mr. CARDIN. I thank you and look forward to working with you on these issues.

Mrs. JOHNSON. Thank you very much, Dr. Wilensky. In looking over some of the parts of your testimony that you didn't get to, I notice that you do have some recommendations regarding Medigap

insurance reform, and that is an issue that I am working on. I look forward to talking with you at another time about those recommendations. Thank you very much for your testimony today.

Ms. WILENSKY. Thank you.

Mrs. JOHNSON. It has been very helpful.

Finally, we will hear from Janet Shikles, the Assistant Comptroller General of the Health, Education, and Human Services Division of the GAO.

Welcome. You have been very, very helpful to this Committee and many, many others, you and your GAO colleagues, and we welcome you here today.

STATEMENT OF JANET L. SHIKLES, ASSISTANT COMPTROLLER GENERAL, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY EDWIN P. STROPKO, ASSOCIATE DIRECTOR, AND TOM DOWDAL

Ms. SHIKLES. Thank you very much. I would like to introduce Ed Stropko on my right and Tom Dowdal on my left.

We are very pleased to be here today to discuss strategies to curb escalating Medicare spending. Over the past few years, we have reported in some detail on several of Medicare's flawed pricing and reimbursement policies and weak controls over utilization.

Today, I would like to summarize these findings and outline several steps that would lead to a better-managed, less costly health care program.

Two areas that illustrate problems due to ineffective reimbursement and utilization controls are home health and skilled nursing facility services. In the case of home health care, Medicare pays home health agencies on the basis of cost, but uses few tools to determine whether the costs are reasonable.

For example, physicians are not required to see patients for whom they sign plans of care. Medicare does not require home health agencies to provide beneficiaries or physicians with information on the home health services that are billed. Only about 3 percent of the home health claims are reviewed before they are paid, and even when reviews are done, Medicare contractors rarely visit home health agencies or beneficiaries to verify that services were actually provided or needed. These minimal controls have resulted in significant inappropriate cost to the Medicare Program.

Turning to SNFs, skilled nursing facilities, this represents another area in which Medicare's reimbursement policies have been exploited. Under Medicare's provisions for reimbursement, providers can bill Medicare directly without the SNF or attending physician affirming whether the items were necessary or provided as claimed.

In January of this year, we reported that a wide array of provider types, including physicians, optometrists, psychiatrists, labs, and medical equipment suppliers, fraudulently or otherwise inappropriately billed Medicare for unnecessary or undelivered services.

We believe that the reimbursement and utilization problems facing Medicare in home health care, skilled nursing facility services, and other services confront private insurers as well, but private in-

surers are equipped with a larger and more versatile inventory of health care management strategies than HCFA currently has.

In stark contrast to private payers, HCFA and its contractors generally cannot use such utilization controls as prior approval or case management to coordinate and monitor expensive services and specialist care, encourage the use of preferred providers who meet utilization, price, and quality standards, negotiate with select providers for discounts, promptly change prices to match those available in the market or competitively bid prices.

If similar approaches were also available to Medicare, the government might be able to avoid spending substantial sums unnecessarily.

In conclusion, helping to move Medicare in the direction of becoming a more prudent manager of health care costs by giving it the tools it needs to pull this off will entail several steps. We believe that Congress should enact funding and contractor reform provisions, similar to those contained in H.R. 3103.

Second, we believe that HCFA needs to target Medicare's high cost, high utilization areas, such as home health and SNF services, for running demonstrations to apply such strategies as the use of case management and contracting with companies specializing in utilization review.

Third, the Congress should give HHS the flexibility to make prompt adjustments to fee schedules when overpriced services and supplies are identified.

This is the recommendation that Congressman Shays was also talking about at the beginning of this hearing.

This concludes my testimony, and we would be pleased to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF JANET L. SHIKLES
ASSISTANT COMPTROLLER GENERAL
HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss strategies to curb escalating Medicare spending. There is no shortage of numbers to illustrate the importance of controlling federal outlays for this program. On average, Medicare spending has grown by over 10 percent a year since 1989--twice the rate of the national economy. Medicare's part A trust fund, which pays for hospital and other institutional services, is projected to run out by mid-2001--a year sooner than projected last year.[1]

Over the past few years we have reported in some detail on several of Medicare's flawed pricing and reimbursement policies and on weak controls over utilization. We have noted how these problems amount to bad business practices and that aspects of the Medicare program must be modernized in today's highly competitive health care market.[2] Today, I'd like to summarize these findings and outline several basic steps that would lead to a better managed, less costly health care program.

In brief, we believe that while the Congress considers long-term restructuring efforts, immediate efforts to improve Medicare's traditional fee-for-service program could bring about much needed savings. This program currently serves about 90 percent of beneficiaries and with better management could run more efficiently while continuing to serve well the nation's elderly. This means allowing Medicare to use tools similar to those used by private payers to manage health care costs. Negotiated discounts, competitive bidding, preferred providers, case management, utilization review--these and other tools enable private payers to use market forces to control health care costs, but most are not authorized for general use by the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which administers Medicare. This results in a publicly financed program that pays higher than market rates for certain services and supplies, and sometimes pays without question for improbably high levels of services. Recent HCFA initiatives and pending legislation passed by the House of Representatives,[3] however, offer promise for making some program improvements. In addition, HCFA should test the feasibility of applying management strategies in high-cost, high-utilization areas. Finally, the Congress needs to give HHS the flexibility to make prompt price adjustments.

BACKGROUND

Medicare is the nation's largest single payer for health care. In 1995, it spent an estimated $177 billion, or 12 percent of the federal budget, on behalf of more than 37 million elderly and disabled people. CBO projects that, under current program law, program spending will almost double in the next 6 years to an estimated $332 billion by 2002. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-service basis; that is, patients chose their own physicians or other health care providers, with bills sent to the program for payment. This set-up mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, many changes have taken place in the financing and delivery of health care. Large health care purchasers have used leverage on hospitals and other providers to obtain lower prices. Private payers, including large employers, use an aggressive management approach to control health care costs. HCFA is

---

[1]Based on CBO's March 1996 baseline projection for Medicare.

[2]A list of related GAO products is at the end of this statement.

[3]H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, passed the House of Representatives on March 28, 1996.

Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by interrelated statute, regulation, and agency policy.

HCFA contracts with about 70 companies--such as Blue Cross and Aetna--to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls in addition to those that have been established nationally by HCFA. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

The health care delivery system has become more complex since Medicare began 30 years ago. In addition to physicians and hospitals, a greater variety of providers bill Medicare, including multilayered corporations providing clinical laboratory services, home health care, rehabilitation therapy, and medical equipment and supplies. Even some of Medicare's claims processing contractors are investing in provider networks, which means that insurance companies responsible for reviewing the appropriateness of Medicare claims are also, through the medical networks they own, billing the program. At a time when the volume of Medicare claims has exceeded 800 million a year, Medicare is being billed increasingly by entrepreneurial entities rather than by medical professionals.

CATEGORIES WITH FASTEST GROWTH RATES COINCIDE WITH THOSE LEAST MANAGED IN MEDICARE

Although growth rates for inpatient hospital and physician services have moderated since the 1980s, Medicare spending remains high. Combined spending for these services amounted in 1994 to $120 billion--nearly three-fourths of total Medicare spending. The sheer size of these categories means that each percentage point of growth represents hundreds of millions of dollars.

Smaller categories of services, however, have displayed much more rapid growth through the 1990s, helping to drive total Medicare spending to double-digit inflation. Home health agency (HHA) and skilled nursing facility (SNF) services each grew at an average annual rate of 28 percent from 1990 through 1996.[4]

Table 1: Average Annual Growth Rates for Selected Categories of Medicare Spending

Numbers in percent

Years	Total	Inpatient	Physician	SNF	HHA
1980-89	10.2	9.5	13.8	27.3	14.0
1990-96	11.3	5.9	7.0[a]	28.0	28.4

[a]Percentage is based on data through 1994.

Private insurers and employer purchasers have sought to stem such health cost escalation by shifting from their role as passive payers to become more prudent managers of health care costs. Some 90 percent of health plans--from fee-for-service to managed care--

[4]This is based on the latest CBO baseline projections for 1995 and 1996, since actual data are not yet available. From 1990 through 1994, the growth rate was even higher--over 35 percent per year.

actively manage costs through price competition and negotiation and utilization monitoring techniques. By contrast, Medicare's reimbursement policies and claims payment activities have not been adapted to the contemporary marketplace and today's demands for fiscal discipline in public programs.

SNF AND HHA CATEGORIES ILLUSTRATE COST CONSEQUENCES OF UNMANAGED HEALTH SERVICES

The home health and SNF spending categories, in particular, illustrate the damaging effects of reimbursement policies that fail to incorporate effective pricing and utilization management techniques.

Inadequate Monitoring of HHA Payments

In the case of home health services, for example, Medicare pays HHAs on the basis of costs but uses few tools to determine whether the costs are reasonable. Also, physicians are not required to see the patients for whom they sign plans of care and are not held accountable if they approve inappropriate levels of service. Medicare does not require HHAs to provide beneficiaries or physicians with information on the home health services billed on their, or their patients', behalf. The Medicare contractors, moreover, pay 97 percent or more of home health claims without review.[5] Even when reviews are done, Medicare claims processing contractors rarely visit HHAs or beneficiaries to verify the actual and appropriate provision of services. One consequence of such neglect is the escalation of visits per Medicare beneficiary, which rose an average of about 20 percent a year from 1989 to 1994.

In July 1995 we reported that the largest privately held HHA in the United States, which was being investigated for fraud, obtained 95 percent of its total revenues from Medicare.[6] Current and former employees told us medical records were altered and forged to ensure continued or prolonged home health care visits. Services were provided to patients who were not homebound[7]--for example, one who routinely drove a vehicle to go grocery shopping and one who walked a few blocks alone daily to eat at the local senior citizens' center.

This company also visited patients more frequently than did most other HHAs. Although wide variation in utilization rates is a key indicator that an inappropriate level of services is being provided, Medicare contractors do not have the capacity to manage home health payments by scrutinizing agencies' claims in markets showing utilization outliers. Our March 1996 report on home health utilization shows huge variations in the level of services provided across geographic areas and provider types.[8] For example, in 1993 patients in southeastern states received on average more than twice as many visits as patients in northwestern states. Furthermore, diabetics received an average of about twice as many visits from proprietary HHAs as from voluntary or government-run agencies.

---

[5]Because of limited resources, contractors' medical review of claims has declined from 62 percent of all claims in fiscal year 1987 to about 3 percent in 1995.

[6]Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

[7]42 U.S.C. 1395f(a) requires that, to qualify for home health services under Medicare, a beneficiary must be confined to the home.

[8]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Inadequate Monitoring of SNF and Ancillary Service Payments

Skilled nursing facilities represent another area in which Medicare's unguarded reimbursement policies have been exploited. In this setting, a population with extensive health care needs grouped together at a single location offers unscrupulous providers the opportunity for volume billing, and Medicare often does not look for warnings of egregious overutilization or rapid increases in billings. Under Medicare's provisions for reimbursement, providers can bill Medicare directly, without the SNF or attending physician affirming whether the items were necessary or provided as claimed. In other words, medical equipment suppliers, providers of rehabilitation therapy, and providers of X rays and other diagnostic tests can determine levels of services and bill Medicare with little or no oversight. In addition, Medicare's automated systems do not capture data in a way that would practically allow them to flag indications of improbably high charges or levels of services at individual facilities. This is in part because the data are not organized to report which beneficiaries are in nursing homes.

In January of this year we reported that a wide array of provider types--including physicians, optometrists, psychiatrists, laboratories, and medical equipment suppliers--have fraudulently or otherwise inappropriately billed Medicare for services and supplies furnished to nursing facility residents.[9] The wrongdoing has generally focused on billing Medicare for unnecessary or undelivered services, or misrepresenting a service to obtain reimbursement. The investigations we reviewed probed activities in over 40 states, with many providers operating in multiple states.

Not only are payments for the ancillary services provided to SNF patients poorly policed, payments to SNFs themselves are difficult to monitor. Medicare pays SNFs on the basis of costs. But as with home health care, Medicare has only limited tools to determine whether the costs are reasonable. This is particularly pertinent to rehabilitation therapy, services that account for 30 percent of SNF costs. Specifically, Medicare places no absolute dollar limits on reimbursements for occupational or speech therapy, and charges for therapy services are not linked through billing codes to the amount of time spent with patients or the treatment provided. In other words, Medicare has no easy way to limit the amount it will pay for occupational or speech therapy or to determine whether a charge is for 15, 30, or 60 minutes of treatment. Absent any benchmarks, and with limited resources available for auditing, it is largely infeasible for Medicare contractors to judge whether therapy providers have overstated their costs.

Last year we reported that Medicare had been charged as much as $600 for an hour of therapy services.[10] HCFA has acknowledged the problem and recently estimated that implementing salary equivalency guidelines for speech and occupational therapy, in conjunction with adjusting other salary guidelines, could save $1.4 billion over the next 6 years. To date, however, the salary guidelines have not been established. Although occupational therapists in SNFs earn on average $23 per hour, we recently found in one contractor's files that more than 25 percent of submitted charges for one unit (undefined) of occupational therapy exceeded $195 and some approached $1,500 per unit.

---

[9]Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

[10]Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Under Medicare rules for reimbursing SNFs, the problem of overpaying for rehabilitation therapy services becomes compounded. That is, Medicare pays SNFs a portion of their overhead expenses, based on the percentage of their total Medicare-related business. The higher the Medicare-related payments to rehabilitation agencies (or other outside contractors), the more Medicare business an SNF can claim, and the higher the percentage of its overhead that can be charged to the program. Further, as noted by the Prospective Payment Assessment Commission (PROPAC), SNFs may cite high use of ancillary services, such as therapy, to justify an exemption from routine service cost limits, thereby increasing their payments for routine (bed, board, nursing) services.[11]

MEDICARE'S RESPONSE TO
LONG-STANDING PROBLEMS TOO
SLOW TO BE EFFECTIVE

Allowing payment problems to continue unchecked results in billions of dollars of unnecessary spending. HCFA has been aware of the rehabilitation therapy overcharging problem since 1990. In 1993 HCFA began studies to develop averages for therapists' salaries. Its most recent analysis is expected to be completed some time this summer. Given the usual time involved in the federal notification and publication requirements for changing Medicare prices, salary equivalency guidelines--which are key to Medicare's determination of reasonable costs--are unlikely to be implemented before the middle of 1997 at the earliest.

This situation is consistent with HCFA's past experience of taking years to adjust excessively high payment rates. It took almost 3 years to lower the price of an item it paid up to 4 times more for than consumers paid at the local drug store. HCFA can adjust prices that are inherently unreasonable, but its authority to do so is very limited and involves a complex set of procedures that take a long time to complete.[12] Because of the time and resources involved, HCFA only occasionally uses this process. In an August 1995 report, we showed that Medicare paid higher than the retail prices for 44 types of surgical dressings.[13] Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, however, even the unwieldy inherent reasonableness authority to change these prices was effectively eliminated. Before 1987, individual Medicare contractors had the authority to adjust prices to reflect local market conditions using a publication and notification process that could be completed in less than 90 days. In a letter to a congressional subcommittee, the HHS Inspector General last year characterized as "absurd" the situation limiting HCFA's ability to make timely adjustments to payment levels.[14]

MEDICARE PROGRAM
OVERDUE FOR CHANGE

Because of strict statutory constraints and its own burdensome regulatory and administrative procedures, HCFA is slow to address overpricing and overutilization problems. As we reported to the Congress last September, many of the tools Medicare's contractors

---

[11]Report and Recommendations to the Congress (Washington, D.C.: PROPAC, Mar. 1, 1996).

[12]The relevant statutory provision is 42 U.S.C. 1395m(a)(10)(B).

[13]Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

[14]Letter dated July 25, 1995, to the Chairman, Subcommittee on Oversight and Investigations, Committee on Commerce, House of Representatives.

use to manage their commercial insurance plans are not authorized for use in the Medicare program.[15]

In stark contrast to private payers, HCFA and its contractors generally cannot

-- use such utilization controls as prior approval or case management to coordinate and monitor expensive services and specialist care;

-- encourage the use of "preferred providers"--those who meet utilization, price, and quality standards; or

-- negotiate with select providers for discounts, promptly change prices to match those available in the market, or competitively bid prices.

Not surprisingly, Medicare's ability to emphasize cost efficiency in its dealings with suppliers, physicians, and institutions that habitually provide excessive services is limited, and for certain services Medicare pays higher prices than its private sector counterparts. (See app. I for details on commonly used private sector strategies and their applicability to Medicare. See also chapter 11 of the Physician Payment Review Commission's (PPRC) 1996 Annual Report to Congress.[16]

The recognition that Medicare needs to change its role from largely a claims processor to prudent manager is beginning to take shape in HCFA itself as well as in pending legislation passed by the House of Representatives last month. For example, HCFA has planned, among several new initiatives,

-- a demonstration testing the concept of competitive bidding for certain supplies, such as oxygen, hospital beds, and urological and incontinence products;

-- an improvement on earlier case management experiments by which primary care physicians would, for example, provide comprehensive management for beneficiaries with specific diagnoses such as diabetes, hypertension, or congestive heart failure, for which Medicare would reimburse them with a bundled, capitated payment as is currently done on a monthly basis for end-stage renal disease patients; and

-- a demonstration in selected locations that allows beneficiaries to join preferred provider organization health plans, which are not currently available under Medicare.

HCFA has interpreted current law as precluding it from contracting with entities other than insurance companies. Certain provisions in the Health Coverage Availability and Affordability Act of 1996 would give HCFA the funding and flexibility to make its contractor network better managers of program dollars. In particular, HCFA[17] would have the authority to contract directly with companies specializing in utilization review and fraud detection to monitor and adjudicate claims. In essence, HCFA could contract with the companies best suited to perform medical, utilization, and fraud reviews; audit cost reports; revisit payment decisions and recover overpayments; provide education on payment integrity and benefit quality assurance issues; and provide more specific guidance on coverage of medical equipment and supplies.

---

[15]Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

[16]Washington, D.C.: PPRC.

[17]Technically, the authority is granted to HHS, of which HCFA is a part.

Increased flexibility and an accompanying assured funding stream, such as that proposed in this legislation, would significantly enhance HCFA's ability to curb overutilization and inappropriate billings.

Despite these initiatives, however, important tools would still be unavailable to the Medicare program. For example, HCFA uses profiling--that is, statistical analyses--to identify "outlier" providers whose practice patterns differ markedly from those of their peers. While the private sector is free to use profiling results to provide financial rewards or penalties (in the form of exclusion from preferred provider networks), HCFA lacks the authority to do so. In addition, HCFA and its contractors have no viable statutory authority to require prior approval of select procedures. Most important, HCFA does not have the authority needed to promptly correct overpricing problems.

CONCLUSIONS

The problems facing Medicare confront private insurers as well, but they are equipped with a larger and more versatile inventory of health care management strategies than HCFA currently has. These strategies may not be deployable in every aspect, but in general they suggest ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care approaches in their capacity as private insurers. If they applied similar approaches to Medicare, the government might be able to avoid spending substantial sums unnecessarily.

Medicare needs to redefine itself from being a passive payer of claims to becoming a prudent manager of health care costs. Major reimbursement reforms may be an ultimate solution, but HCFA needs to begin immediately to manage Medicare's high-growth-rate areas, such as home health and SNF care. Reducing services and prices to appropriate levels is paramount before locking in existing cost structures through payment system reforms. This will entail several steps:

1. The Congress should enact funding and contractor reform provisions similar to those contained in H.R. 3103. Such reforms would give HCFA the flexibility to hire the private sector expertise necessary to apply the best health cost management practices.

2. HCFA needs to target Medicare's high-cost, high-utilization areas for running demonstrations to apply such strategies as the use of case management and companies specializing in utilization review. For example, HCFA could identify, as the focus of the demonstrations, geographic areas with particularly high home health or SNF costs per Medicare beneficiary.

3. The Congress should give HHS the flexibility to make prompt adjustments to fee schedules when overpriced services and supplies are identified. For example, Medicare should be able to reduce fee schedule prices for surgical supplies within 90 days, similar to what was customary before OBRA 1987.

We have included as appendix II a list of GAO recommendations recently made to correct specific Medicare payment problems.

- - - -

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

For more information on this testimony, please call Edwin P. Stropko, Associate Director, at (202) 512-7119. Other major contributors included Audrey Clayton, Patricia Davis, Hannah Fein, and Barry Tice.

COMMON PRIVATE SECTOR STRATEGIES AND APPLICABILITY TO MEDICARE

Private sector strategy	Description	HCFA's current practice	HCFA explanation
Prompt reaction to market prices	Change prices quickly when paying more than competitively necessary	Prices generally not adjusted for declines in the price of product or service[a]	Pertinent statute generally permits appropriate adjustments only after a complex administrative process[b]
Negotiate with select providers	Selectively contract with providers to deliver certain services, such as hip replacements, at a specific price	Same payments generally made to any provider selected by beneficiary to provide services	Statute does not permit providers to be excluded unless they engage in certain prohibited practices[c]
Competitive bidding and negotiations	Set prices for services or service packages based on competitive process	Prices are set under complex formulas, but demonstration involving competitive procedures is proposed	Statute generally provides only for all area providers to be paid the same amount for service;[d] legislation prohibits proposed demonstration[e]
Preferred provider network	Promote use of a network of select providers meeting price, practice style, and quality criteria	Payments generally made to any provider selected by beneficiary to provide medical services	Statute guarantees beneficiary freedom to choose providers;[f] statutory authority to contract with health maintenance organizations (HMOs) only[g]
Prior authorization	Require prior approval of select procedures	No prior approval of hospitalizations or other procedures	No viable statutory authority for requiring prior approval; statute prohibits interference with practice of medicine[h]
Case management	Assist high-cost patients in selecting appropriate services efficiently	Assistance not provided to patients in selecting services efficiently	Statute prohibits interference with practice of medicine[i]
Contract with utilization review companies	Use companies specializing in utilization review to monitor and adjudicate claims	HCFA contracts with private entities--generally insurance companies--to process claims[j]	Statute provides no specific authority for contracting with utilization control organizations[k]
Greater use of commercial technology to detect billing abuses	Use off-the-shelf software that flags billing problems and automatically adjusts payments	HFCA directs contractors to develop system capabilities, without guidance on use of specific technologies	HCFA concerned about adaptability and relevance to Medicare

[a]For example, although 42 U.S.C. 1395u(b)(8) and (9) provide HCFA with authority to adjust payments when the established rates under a fee schedule are found to be inherently unreasonable, detailed procedures are mandated that include a lengthy notice and comment period.

[b]For example, 42 U.S.C. 1395m(a)(10)(B) provides HCFA with authority to adjust prices for durable medical equipment, excluding surgical dressings, but only after completion of a cumbersome administrative process. The one time this process was used, it took 3 years to complete.

[c]42 U.S.C. 1320a-7 provides for mandatory and permissive exclusion of providers who are, for example, convicted of certain program-related crimes.

[d]42 U.S.C. 1395f establishes conditions of and limitations on payment for services.

[e]In 1985, HCFA started the process to perform a demonstration of competitive bidding related to laboratory services, and it was set to begin in 1987. That year and in several subsequent years, however, provisions were included in the respective budget reconciliation laws specifically prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce competitive bidding, without success.

[f]42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[g]42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances.

[h]42 U.S.C. 1395.

[i]42 U.S.C. 1395.

[j]These companies may arrange for utilization review to be done under subcontract.

[k]42 U.S.C. 1395h provides detailed authorization for HCFA to contract with private entities without competitive procedures to handle part A claims, and 42 U.S.C. 1395u provides similar authority for part B claims.

SPECIFIC RECOMMENDATIONS MADE IN RECENT GAO REPORTS

Cited below are our recommendations and matters for congressional consideration addressing specific reimbursement system and payment control problems.

MEDICARE: HOME HEALTH UTILIZATION EXPANDS WHILE PROGRAM CONTROLS DETERIORATE (GAO/HEHS-96-16, Mar. 27, 1996)

Matters for Consideration by the Congress

The emphasis of Medicare's home health benefit program has recently shifted from primarily posthospital acute care to more long-term care. At the same time, HCFA's ability to manage the program has been severely weakened by coverage changes mandated by court decisions and a decrease in the funds available to review HHAs and the care they provide. The Congress may wish to consider whether the Medicare home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a posthospital acute care benefit. The Congress should also consider providing additional resources so that controls against abuse of the home health benefit can be better enforced.

FRAUD AND ABUSE: PROVIDERS TARGET MEDICARE PATIENTS IN NURSING FACILITIES (GAO/HEHS-96-18, Jan. 24, 1996)

Recommendation to the Congress

To curtail the practice of giving providers unauthorized access to beneficiary medical records, the Congress should authorize HHS OIG to establish monetary penalties that could be assessed against nursing facilities that disclose information from patients' medical records not in accord with existing federal regulation.

Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

-- establish, for procedure billing codes by provider or beneficiary, thresholds for unreasonable cumulative levels or rates of increase in services and charges, and to require Medicare carriers to implement automated screens that would suspend for further review claims exceeding those thresholds and

-- undertake demonstration projects designed to assess the relative costs and benefits of alternative ways to reimburse nursing facilities for part B services and supplies; these alternatives should include such options as unified billing by the nursing facility and some form of capped payment.

MEDICARE SPENDING: MODERN MANAGEMENT STRATEGIES NEEDED TO CURB BILLIONS IN UNNECESSARY PAYMENTS (GAO/HEHS-95-210, Sept. 19, 1995)

Recommendations

We recommend that the Secretary of HHS direct the HCFA Administrator to

-- develop policies and revise practices so that Medicare can (1) price services and procedures more competitively, (2) manage payments through state-of-the-art data analysis methods and use of technology, and (3) better scrutinize the credentials of vendors seeking to bill the program;

-- examine the feasibility of allowing Medicare's commercial contractors to adopt for their Medicare business such managed care features as preferred provider networks, case management, and enhanced utilization review; and

-- seek the authority necessary from the Congress to carry out these activities.

Matters for Congressional Consideration

Given the urgency for expediting Medicare program changes that could lead to substantial savings, the Congress may wish to consider directing the Secretary of HHS to develop a proposal seeking the necessary legislative relief that would allow Medicare to participate more fully in the competitive health care marketplace. Such relief could include allowing the Secretary of HHS to set maximum prices on the basis of market surveys, or, if the formal rulemaking process is preserved, allowing the Secretary to make an interim adjustment in fees while the studies and rulemaking take place.

The Congress may also wish to consider options for granting relief from the funding declines in Medicare's anti-fraud-and-abuse activities.

MEDICARE: EXCESSIVE PAYMENTS FOR MEDICAL SUPPLIES CONTINUE DESPITE IMPROVEMENTS (GAO/HEHS-95-171, Aug. 8, 1995)

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to

-- require that bills submitted to fiscal intermediaries itemize supplies;

-- develop and implement prepayment review policies as part of the process of implementing any new or expanded Medicare coverage; and

-- establish procedures to prevent duplicate payments by fiscal intermediaries and carriers.

Matter for Congressional Consideration

The fee-schedule approach to setting prices provides a good starting point for setting appropriate Medicare prices. HCFA, however, needs greater authority and flexibility to quickly adjust fee-schedule prices when market conditions warrant such changes. To allow Medicare to take advantage of competitive prices, the Congress should consider authorizing HCFA or its carriers to promptly modify prices for durable medical equipment (DME) and other medical supplies. For this to work effectively, however, HCFA or the carriers must devote adequate resources to routine price monitoring.

MEDICARE: TIGHTER RULES NEEDED TO CURTAIN OVERCHARGES FOR THERAPY IN NURSING HOMES (GAO/HEHS-95-23, Mar. 30, 1995)

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to (1) set explicit limits to ensure that Medicare pays no more for therapy services than would any prudent purchaser; (2) strengthen certification requirements to better ensure that those entities billing Medicare are accountable for the services provided to beneficiaries; and (3) define billable therapy service units so they relate to the time spent with the patient.

RELATED GAO PRODUCTS

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

Fraud and Abuse: Medicare Continues to be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995).

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

Mrs. JOHNSON. Thank you very much.

I understand that toward the back of your testimony there is a chart that lays out these private sector strategies that you believe could be adopted to Medicare. In reviewing that chart, I wonder which strategies HCFA could do on its own through its administrative power and which ones would require changes in the law.

Ms. SHIKLES. We think that case management or most of these except perhaps the top one on changing market prices, they could certainly do on a demonstration authority. We have been pushing HCFA for some time, and I know this Committee has, to move out in a more aggressive way and certainly look at some of the activities used by private companies that are managing the indemnity side of the insurance business.

PPRC also just did a survey of Blue Cross plans to look at the same issue, and we believe that HCFA could have been running demonstrations particularly in these very high-growing areas, the postacute services on part A, testing case management, the utilization review strategies, perhaps PPOs, and then learning from those efforts and they could then come to this Committee and say these worked, these didn't work, and then ask for legislative relief.

On the first one, on changing prices quickly, they need legislative action. Back in 1987, Medicare used to be able to, on the basis of a quick market survey that alerted that it was paying at high rates when everybody else was paying at lower rates, in a period of 90 days, they could change prices in that market.

After 1987, it is really not possible for Medicare to do that quickly. They have to now take the whole Administrative Procedures Act, follow it through, and it can take up to 3 or more years to make a change on a price for a particular item.

So what we have recommended is that Congress consider at least giving the Medicare Program authority to at least make an interim change when it identifies really egregious prices, and then if the Congress wanted, they could follow through on the long procedures and issue a final rule. This would restore public confidence that Medicare is not overpaying for a particular item.

Mrs. JOHNSON. What was the cause of that change in 1987? Was it a change that went on for other reasons and simply affected this price-setting capability of HCFA?

Ms. SHIKLES. Yes. I believe that at that time a set of fee schedules were put in place nationally, and I think the thinking was that you would have uniform fee schedules and that somehow that would take care of the problem. So I don't think it was intended to cause the problems it subsequently did.

Mr. DOWDAL. Yes, that is correct. The restriction on changing prices came into being mainly with the fee schedules when there was feeling that prices would be national and not modified locally. Although there are authorized variations, the law didn't recognize that there could be pricing problems that arise.

On your first question, the only one of those strategies in our list that HCFA would definitely have legal authority to do now is the last one related to the claims processing systems and using different kinds of software. The rest of them, there would need to be legislation of some kind.

Mrs. JOHNSON. Which ones would you have the greatest confidence in, in the sense of urging clear legislative authority now rather than going through the demonstration process, or would you recommend legislative authority for all of them?

Ms. SHIKLES. Do you want to answer that?

Mr. STROPKO. I certainly think changing prices to market prices is pretty clear cut and should be dealt with very quickly from HCFA's perspective. They have the infrastructure to do it, and they have a large contractor network that could provide the information necessary to do it if authorized by law.

Certainly, prior authorization has been done in the past, and that is an area where, when abuse is apparent, it seems to me HCFA could very easily be given the discretion to allow prior authorization certainly on a geographic-specific basis. So those seem to be the most direct.

Competitive bidding, preferred provider networks, and case management get HCFA into a degree of management that it is not necessarily accustomed to providing directly, and that is where demonstration authority might be most appropriate.

Mrs. JOHNSON. Thank you.

Mr. McCrery.

Mr. MCCRERY. Thank you.

I appreciate the work that you did and the conclusions that you have drawn. They make a lot of sense. Would it make sense to you to adopt reforms in Medicare that would allow senior citizens to choose private sector plans that already have these kinds of enforcement tools or cost-saving tools available to them?

Ms. SHIKLES. I think it would. In fact, our second recommendation here, in terms of even absent larger legislation, we believe that HCFA now using its demonstration authority could go into the Los Angeles market and contract with a lot of private companies out there to offer preferred provider panels, home health services, case management, or any of these activities. That is what we are strongly pushing HCFA to do using the demonstration authority.

If you are an individual in a private indemnity plan, you are subject to most of these different types of activities. It is Medicare that the fee-for-service side is basically less managed right now.

Mr. MCCRERY. Thank you.

Thank you, Madam Chairman.

Mrs. JOHNSON. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman.

I, too, appreciate the work that you all have done in looking at ways in which HCFA can save money in the administration of Medicare.

I agree that HCFA needs more flexibility in pricing on one of your recommendations, as also our colleague, Congressman Shays, has pointed out.

I hope that goes both ways. Let me just give you an example. It was brought to our attention by a person who needed an implant that automatically releases drugs into your system. Medicare would pay for the procedure, which was very expensive, about $30,000 if I remember correctly, and that if it didn't work, they would pay for the removal of the implant. But, they wouldn't pay

for the test to see whether it would work or not because that wasn't covered, which was one-tenth of the cost of the process for the implant itself.

So I would hope that as we look at flexible pricing that that type of discretion would be given to HCFA to be able to look at more cost-effective ways of dealing with costly procedures in an effort to save money for Medicare. Is that what you are intending to do?

Ms. SHIKLES. Absolutely, and I should have said that. We think that the program needs to have more flexibility, and you can't run with these very rigid rules that end up in situations like the one you just described that are just terribly wrong.

We would agree that if you could go in and do a quick survey of market prices, in some cases, Medicare may need to raise its prices. I think you want to be certain that beneficiaries have access to the very best care, and I don't think you want Medicare to be the lowest price payer in an area either, because you want to be able to pay enough to buy good quality care and comprehensive care.

Mr. CARDIN. It is sometimes very sad that you find Medicare will overpay in some costly areas, but will not pay an adequate amount in less costly procedures, forcing people into the more costly options in order to get reimbursed rather than more cost-effective options.

I hope that it would be balanced, and I appreciate your response on that. I hope that we can develop recommendations that will give HCFA this ability and that it will use it appropriately in order to save money for our system.

Thank you.

Ms. SHIKLES. I remember we did study, and I don't know if it is still true, where Medicare would pay for the cataract surgery, but we wouldn't pay for the glasses after the surgery.

Mr. CARDIN. Right.

Ms. SHIKLES. So you couldn't see, then.

Mr. CARDIN. We all hear about those in our congressional office. We are wondering if someone is looking at this, and every once in a while, we find they don't have the legal authority.

Ms. SHIKLES. That is the problem.

Mr. CARDIN. I would hope that Congress would give our administrator the necessary discretion in order to have a more cost-effective system.

Thank you.

Mrs. JOHNSON. Thank you.

Actually, I was interested in your explanation that HCFA lost that flexibility when we put in the national fee schedule. Now we desperately need the ability to adjust for aberrations that develop.

I think some of the things that we are proposing already will give us more money for both contracting for utilization review companies and greater use of commercial technology to detect billing abuses, but I think probably the utilization review is amongst the most important.

Ms. SHIKLES. I think I would agree with that.

Mrs. JOHNSON. We have little less management experience in the other areas, and we in the end are not going to be the ones who develop these networks.

I appreciate your testimony. It was very, very helpful today.

On the home health reimbursement issue, perhaps you could enlarge on your specific recommendations in that area because we are having a terrible time pricing out the savings of proposals, and I think most Members are getting a very different picture from their providers out there in the field versus CBO and other estimators of these proposals. So any comments that you might have on that, I would appreciate.

Ms. SHIKLES. We have just issued a report on the home health care whole benefit, and it has jumped from about $3 billion in 1989 to about $13 billion in 1994. CBO predicts that it will now increase to $30 billion in the year 2002. I think that and the other nonhospital services in part A are contributing to some of the stress in the part A fund.

Mrs. JOHNSON. To that point, does your study look at what portion of that increase is associated with a reduced number of dates in acute care hospitals?

Ms. SHIKLES. No.

Mr. DOWDAL. No. The conclusion we came to is that home health has become more of a long-term care benefit than it used to be when it was primarily a posthospital, acute care-type benefit. So the number of visits per beneficiary receiving home health care has gone up by factors of three, four, five, and even more than that.

Mrs. JOHNSON. The difficulty with that is looking at it in isolation isn't very helpful when we sought to reduce the number of acute care days. We knew we would increase the number of home care visits. So one of the things I need to know is how many of those home care visits represent reducing health care costs because they are bringing people out of the hospital earlier, and then what percentage of those longer term home health visits are also reducing costs because they are keeping people out of nursing homes.

I do actually see that in my daily life. So does your research go to either of those two points?

Ms. SHIKLES. We will get you the information that will show you how many people are using home health who didn't have a prior hospitalization, but we can't tell from the data that it would have prevented a nursing home admission.

Mrs. JOHNSON. Even in States where they have a very sophisticated program—I know in Connecticut, we have a very sophisticated organization called CCCI, Connecticut Community Care Inc.

Ms. SHIKLES. I am familiar with that.

Mrs. JOHNSON. I think their data ought to be pretty good about the extent to which they have been able to keep people out of nursing homes because that was their mission.

They don't get people. They don't get clients until they are at risk of going into nursing homes.

Ms. SHIKLES. Right.

Mrs. JOHNSON. I don't think this number-of-visits issue can be looked at in isolation.

Did you have further comment?

Mr. DOWDAL. No.

Mrs. JOHNSON. So, if you could help me look at that, I think we are having a terrible time dealing with this area because we aren't able to interpret the data relative to savings in other areas. I think

your comment about the number of services that are not physician-authorized or physician-overseen raises some questions.

Also, how much do you want to pay for physician time because, under managed care plans for the most part now, they don't pay for this. How much physician time do we invest in reviewing a care plan, or are there triggers that can be put in place so that when the time comes there is the review? It is those kinds of issues I would be interested in.

Ms. SHIKLES. I am a little familiar with your program in Connecticut and some similar programs, and we would love to see a demonstration at least for the Medicare benefit on home health care because that is when these services are really used either from a posthospital experience or to prevent nursing home admission or help somebody maintain independence at home.

We will come up and meet with you and show you the data we have that some of the utilization you are not certain whether it is really more just the fact that home health agencies now are competing with each other just to offer more and more services.

Mr. DOWDAL. Yes. When I thought about it a minute, what you are saying, Mrs. Johnson, is similar to what we were saying. Home health has become more of a long-term care program than posthospital acute care, and when you are taking care of people over protracted periods of time, whether it is related to nursing home programs or home- and community-based care and all of that, that is one of the points that we are making in the report. It has become more of a program for long-term care.

Congress didn't do anything specifically to say go ahead and do shift toward long-term care, and one of the things we are pointing out in the report is that Congress may want to consider whether that is the direction they want Medicare to move in for the home health benefit.

Mrs. JOHNSON. Certainly, we need to be clear about that. We also need to be clear on whether there is a better way of seeing whether services that are being provided are necessary.

Mr. McCrery, do you have any further comments?

Mr. MCCRERY. No.

Mrs. JOHNSON. Thank you very much for your testimony. We appreciate it. We look forward to working with you.

Ms. SHIKLES. Thank you very much.

Mrs. JOHNSON. The hearing is adjourned.

[Whereupon, at 5:03 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

HIAA
Health Insurance Association of America

Bill Gradison
President

April 26, 1996

The Honorable Bill Thomas
Chairman, Ways and Means Health Subcommittee
United States House of Representatives
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Bill:

On Tuesday, April 30, the Ways and Means Health Subcommittee will be holding a hearing on the Annual Report to Congress of the Physician Payment Review Commission (PPRC). The Health Insurance Association of America (HIAA) is extremely concerned about the direction the PPRC is taking in their study of the Medicare Supplemental Insurance market. While the Commission has not made any formal recommendations on policy changes to the Medicare Supplemental market, HIAA is concerned that the assumptions being used by the PPRC would set a course that could eventually eliminate or adversely impact the availability of private Medicare Supplemental insurance to millions of consumers.

Medicare Supplemental products offer consumers needed security and choice, and protect them from unforeseen medical expenses. Currently, approximately sixty-six percent of seniors eligible for Medicare have some form of private Medicare Supplemental insurance policies. Obviously, any public policy recommendations that would adversely impact these consumers are of great concern.

HIAA submitted its concerns about this matter to the PPRC in a letter dated February 21, 1996. We would like to submit the enclosed copy of that letter for the hearing record.

HIAA will be following this issue closely, and we look forward to working with you and others on the Ways and Means Health Subcommittee and the Physician Payment Review Commission to provide a better understanding of the importance of Medicare Supplemental insurance policies for seniors.

Sincerely,

Attachments

555 13th Street, NW Suite 600 East, Washington, DC 20004-1109 202-824-1623 Fax 202-824-1719

Health Insurance Association of America

Bill Gradison
President

February 21, 1996

Gail R. Wilensky, Ph.D.
Chair
Physician Payment Review Commission
2120 L Street NW Suite 200
Washington, D.C. 20037-1527

Dear Gail:

Enclosed please find HIAA's comments on draft chapter 16 of the Commission's upcoming report to Congress: "Secondary Insurance for Medicare Beneficiaries." We appreciate having the opportunity to comment on these matters of extreme importance to Medicare beneficiaries, Medicare supplemental insurance carriers, and Medicare replacement plan contractors.

We look forward to ongoing dialogue on these issues with you and the Commission during 1996. Please contact me if I can help facilitate the Commission's studies in this area. If your staff has questions related to the enclosed comments, they may contact Marianne Miller in HIAA's Policy Development and Research Department at 202-824-1693.

Sincerely,

Bill Gradison

555 13th Street, NW Suite 600 East, Washington, DC 20004-1109 202-824-1623 Fax 202-824-1719

PPRC 1996 Report to Congress - Chapter 16
"Secondary Insurance for Medicare Beneficiaries"

HIAA Comments on February 13, 1996 Draft
February 21, 1996

HIAA is deeply concerned about the underlying premise of this chapter, which is that Medicare supplemental insurance is somehow illegitimate. The Commission's health economists appear to have decided that there is a "right" level of health care use by Medicare beneficiaries, and that this "right" level is the one that would result if all beneficiaries had to pay the statutory Medicare deductibles and co-insurance out of their own pocket. We find no such limitation in the statute. Rather, the only statutory test for Medicare payment that we are aware of is that the care rendered to an eligible beneficiary be medically necessary. As the chapter points out, the available research finds that imposing beneficiary cost-sharing reduces use of necessary, as well as unnecessary, care.

Moreover, the benchmark for this "right" level of utilization appears to be the claims experience of the 10% of Medicare beneficiaries who have no secondary coverage of any kind. The results of the multivariate analysis are not presented, so we cannot critique them. But one is left with a nagging sense that the 10% must be unusual in some way, most likely with respect to income. Surely the Commission does not want to argue that Medicare should be responsible only for the level of utilization demanded by beneficiaries who are too poor to see a doctor until their need is urgent.

Another general concern relates to the chapter's discussion of Medicare supplemental product rating and underwriting practices. The chapter throughout seems to favor "equivalent" rules for Medicare supplemental and Medicare replacement (risk contract) policies. This stance, if translated to requirements for guaranteed issue and community rating of supplemental policies, ignores the implications for Medicare program costs of the inevitable adverse selection against Medicare supplemental insurers and traditional Medicare which would result. We are convinced that these costs would be significant. (See the enclosed HIAA Legislative Issue Brief #4.)

Additionally, we take issue with the chapter's discussion of rating practices. Indeed, several rating approaches are available in the marketplace. We believe this variety serves the public well by letting them decide for themselves which approach best serves their needs. To eliminate one or more of the current alternatives (on the grounds that the presence of the alternatives is "too confusing") displays Washington hubris of the worst sort. Rather than eliminate rating alternatives for

Medicare supplemental plans, perhaps we should expand them for risk contractors.

We particularly take issue with the allegation that attained-age rating is more costly to beneficiaries over a lifetime. A recent actuarial analysis by Blue Cross of California (attached) demonstrates that, under assumptions which reflect the current marketplace, attained-age rating actually results in a lower lifetime rate than either community rating or entry-age rating.

Specific Comments

1. p. 7, l. 20. Should "insurers" be "employers"?

2. p. 8, l. 24. Should read 14 percentage points.

3. p. 10, l. 20-25. See general comments. If there is legislative history that refers to this "purpose" of Medicare cost-sharing requirements, please cite it.

4. p. 12, l. 5-10. See general comments.

5. p. 12, l. 18-19. See general comments.

6. p. 13, l. 14-18. See general comments regarding attained age rating.

7. p. 13, l. 24 footnote. See general comments. We believe this line of argument is greatly exaggerated, especially in the current environment.

8. p. 14, l. 12-16. This comment has nothing whatever to do with rating practices and should be deleted.

9. p. 14, l. 19-21. Medicare supplemental carriers must offer all Med Supp products they sell on a guaranteed issue basis during a beneficiary's initial 6 months of eligibility for Medicare Parts A and B.

10. p. 14, l. 23-25. This comment appears at odds with the chapter's suggestion elsewhere that risk contracting managed care plans are experiencing favorable selection.

11. p. 14, l. 25-29. There is no problem for ill beneficiaries who purchase Medicare supplemental insurance in their initial eligibility period. The issue for poor beneficiaries is one of income and has nothing whatever to do with rating practices.

12. p. 15, l. 7-11. The larger problem here is that community rating and open enrollment would create severe adverse selection for Medicare supplemental products, raising premiums and making supplemental coverage unaffordable for many beneficiaries. This would occur because beneficiaries would now be able to defer purchasing a med supp product until they become ill enough to really need the benefits it provides (e.g., prescription drug

coverage). The implications for Medicare may be equivocal (in our view), but the implications for supplemental coverage are absolutely clear: higher premiums for all purchasers.

13. p. 16, l. 26-33. The existence of supplemental coverage is not inconsistent with use of financial incentives to affect utilization. Supplemental products could be designed that would pass through financial incentives from the underlying Medicare program, if the regulatory regime permitted it. The larger difficulty is the political one of attempting to reduce the flow of public dollars to particular providers.

14. p. 19, l. 13-14. Though obviously shorthand, this sentence is inaccurate and offensive - betraying the commission's bias on the issue. See general comments.

15. p. 19, l. 15-19. The first two "other options" deserve more discussion. As noted above, use of financial incentives to affect utilization is not incompatible with supplemental insurance.

16. p. 21, l. 1. Our understanding is that, under current law, Medicare risk contractors may not charge beneficiaries for Medicare benefits but only for supplemental benefits.

17. p. 21, l. 17-18. Pooling of risks does not lower costs; it shifts or shares them. Greater bargaining leverage over providers is another issue.

18. p. 21, footnote. There is a fundamental difference in the methods used for determining MIG capitation rates vis-a-vis risk contractor payments (based on the AAPCC). The former are based on the claims experience of enrollees in that arrangement; the latter are derived from the claims experience of beneficiaries remaining in traditional Medicare.

19. p. 22, l. 8 +. The chapter should introduce the discussion of "unified insurance" more deliberately, by defining it and describing the origin of the concepts and the extent of public discussion which has taken place about it.

20. p. 23, l. 18-21. It strikes us as a false premise that Medicare reform must maintain parity between coverage options available in the public vs. the private sector, or that private sector competition is somehow diminished when public sector options are restricted. We believe the notion of "unified insurance" needs considerably more public airing.

21. p. 24, References. We appreciate your citing Mr. Gradison's letter (in footnote 8), but it should then be listed in the References.

STATEMENT OF MARIANNE CZOCH
PRESIDENT AND CEO
VISITING NURSE SERVICE SYSTEM
ON BEHALF OF THE
VISITING NURSE ASSOCIATIONS OF AMERICA

Introduction

Mr. Chairman, I am pleased to submit before this subcommittee the views of the Visiting Nurse Associations of America (VNAA) on how we believe the Medicare program can take a positive direction in the area of home health care. VNAA is the national membership organization and economic alliance for Visiting Nurse Associations (VNAs). Our mission is to support and advance VNAs in their individual communities. By strengthening their role at the community level, VNAA helps VNAs continue to add significant value to the American health care system.

VNAs are freestanding, non-profit and Medicare-certified home care agencies. They represent 46% of all non-profit home health agencies in the United States. Together, they serve over eight million patients annually. Their mission is to provide innovative, cost-effective, and high-quality health care to their patients regardless of their ability to pay. While VNAs are united in mission, they are by nature individually unique in that they tailor services to meet the particular needs of their communities. Governed by voluntary boards of community leaders, they are in tune with community resources and, therefore, can respond quickly to crises. Following the tradition of Florence Nightingale, they spearheaded some of the nation's very first wellness programs. VNAs were well established accross the country before the turn of the century.

For over 100 years, VNAs have helped patients overcome illness and injury, and cope with disability and death, in the comfort of their own homes. Their history places them in the forefront of the home health care field with their ability to meet comprehensive and specialized needs. Today, VNAs provide basic home health services, including skilled nursing and rehabilitative therapy. They also provide non-medical long-term care services, including social services, personal care and housekeeping. High-tech services traditionally only provided by hospitals, including chemotherapy, ventilator care, blood transfusions, pain management and renal dialysis, are now routinely provided by VNAs. VNAs' specialty services include adult day care, Meals on Wheels and hospice.

Medicare's future is significant to VNAs and their patients. VNAs serve Medicare's oldest and sickest home health patients. Seventy percent of VNAs' received revenue is from Medicare, which reflects VNAs' patient population, of whom over 71 percent are persons over age 65. We are the safety net for some of the nation's most vulnerable populations, including poor women at risk of delivering premature infants, children with congenital disabilities, and HIV/AIDS and other terminally-ill patients. We care for those who are denied services, either because they are not poor enough to qualify for Medicaid, because Medicare or Medicaid do not fully cover the services they need, or because they have exhausted their private insurance. Volunteers and charity support from philanthropic sources allow VNAs to provide unreimbursed care. Our capacity to serve is limited only by restraints in available funding.

We, therefore, are deeply concerned about recent reports that the Medicare Part A Trust Fund, which primarily funds Medicare home health care, is in serious financial trouble.

According to HCFA, Part A accrued a deficit of $4.2 billion during the first half of fiscal year 1996. This report has lead to speculation that the Part A Trust Fund will go broke by 2000. This situation, combined with decreasing Medicaid expenditures and charitable contributions, threatens VNAs' future ability to provide health and long-term care to the elderly, persons with disabilties, and the poor. We would very much would like to work with Congress to help resolve these issues and appreciate this opportunity to share our policy recommendations.

Recommendations

VNAA believes that the Medicare home health prospective payment system (PPS) recently presented to key congressional committees by the home health industry will help keep the Medicare Part A Trust Fund solvent. We joined the other three national home health associations in developing this PPS plan and we enthusiastically endorse it. This plan, titled, "Revised Unified Proposal for a Prospective Payment System for Medicare Home Health Services," is a modification of the original PPS plan submitted to Congress in 1995. The modifications were made to the original proposal to respond to HCFA's concerns about implementation feasibility. We believe that the revised PPS plan incorporates the best elements of the home care PPS provisions in HR 2491, which was passed by Congress, and HR 2530, which was introduced by the Administration. It represents months of work and refinement by the home care industry.

This plan calls for three steps to achieve the PPS. Phase I creates an interim PPS plan that incorporates existing cost and utilization data. It accounts for agency case-mix variation by basing aggregate payment limits on an agency's base year performance. Phase II incorporates episodic payment caps based on 18 case mix categories to control utilization. It incorporates data from HCFA's Phase II per episode PPS demonstration project. Phase III moves to a pure per episode PPS with a refined case mix adjuster to reliably and accurately predict variation in costs by case mix. Growth rates would be set below projected spending to assure Medicare savings. Home health agencies that are able to keep their payments below the limits will share the savings with the government up to a maximum of 10% of payments. The attached fact sheet goes into more detail about this revised PPS plan.

VNAA particularly supports the plan's utilization controls. We believe that controlling over-utilization, not cost of care, is the key to producing significant savings in the Medicare home health program. Congressional Budget Office (CBO) analysts generally agree that controlling use is the key to the next generation of Medicare cost containment. An August, 1995, *Eli's Home Health Care Report* discussed findings of the HHS Office of the Inspector General (OIG) report, entitled, "Variation Among Home Health Agencies in Medicare Payments for Home Health Services." The article stated, "Medicare's costs for home health care are being driven by a small number of home health agencies that are providing up to seven times as many visits per patient as low-cost HHAs..... While the average reimbursement per visit was similar among all four groups of HHAs, varying no more than $2 from the national average of $58.06, 'the number of visits varied widely,' the OIG reports."

VNAs are proud of their legacy of cost-efficiency and quality care. The following information demonstrates our ability to meet patients' needs at a reasonable cost to the government and patients. If enacted, we believe that the industry's revised PPS plan will be the catalyst to bringing all home health agencies within the same pattern of cost-efficiency -- providing only the necessary number of visits, providing quality of care, and connecting the patient with community resources that enable them to remain at home. The average number of visits per beneficiary receiving home health services in 1993 from voluntary agencies (i.e. VNAs, Easter Seals Societies) was 46.1, compared to 56.7 for all home health agencies combined; yet we maintain high quality services as demonstrated in our patient satisfaction survey results (95-100% of patients report satisfaction) and percentage of patient goals achieved VNAA members are Medicare-certified and 82 percent are nationally accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP).

A 1996 Abt Associates, Inc., study, using a sample of HCFA claims data from 1994, compared VNAs with other home care agencies on the following measures: 1) mean visits and reimbursement for episodes ending within 120 days and for episodes extending beyond 120 days; 2) mean visits for episodes ending within 120 days and for episodes extending beyond 120 days by census region; 3) mean number of episodes by census region; and 4) mean visits per episode by admission diagnosis.

The Abt study demonstrated that, on average, total reimbursements to VNAs for episodes of care that extended beyond 120 days were $1,876 less than reimbursements to non-VNAs for such episodes. And, total reimbursements to VNAs for all episodes of care (those that end within the first 120 days and those that extend beyond 120 days) were $896 less than reimbursements to non-VNAs for such episodes. In terms of utilization, VNAs were also favorably compared. By census region, VNAs provide fewer visits per total episode than do non-VNAs by every census region except the Mid Atlantic. They also have two-three times more episodes by region that do non-VNAs. Finally, VNAs provide fewer visits per episode in 41 out of 44 diagnosis categories than do non-VNAs. This latter finding demonstrates that VNAs' efficiency is not due to a lighter caseload. In fact, the March 1996 U.S. General Accounting Office (GAO) report, entitled "Medicare: Home Health Utilization Expands While Program Controls Deteriorate," points to VNAs' cost-efficiency when treating similar types of chronic and acute cases (described below).

The GAO report addresses that there are justifiable reasons for the growth in the home health benefit; for example, the lawsuit filed in 1988 (Duggan v. Bowen) that struck down HCFA's interpretation of benefit coverage requirements. "As a result of the suit, HCFA revised the Medicare Home Health Agency and Medicare Intermediary manuals in 1989 so that the criteria for coverage of home health visits would be consistent with 'part-time or intermittent care,' as required by statute, rather than 'part-time and intermittent care,' as HCFA had been interpreting it," states the report. Following those manual changes, the percentage of Medicare beneficiaries receiving home health services and the number of home health visits received per year per home health user have increased signficantly.

However, while changes in Medicare law, regulations, and policy have affected all home health agencies similarly, there is still stark contrast in utilization patterns between types of home health agencies (e.g, non-profit VNAs, hospital-based agencies, for-profit proprietaries). To learn about the cause of these different patterns, the GAO conducted an episode-of-care analysis for four diagnoses: diabetes, heart failure, hypertension, and hip fracture. What they learned from this analysis is that when different types of agencies treat the same severe diagnoses, a contrast in number of visits provided per beneficiary still exists between types of agencies even when case mix is controlled. There were differences in episode length as well. For diabetes, voluntary agencies' average visits were 30.5, compared to 38.2 for all home health agencies combined; and length of episode was 55.3 compared to 59.0, respectively. For heart failure, hypertension, and hip fracture, average number of visits per beneficiary and lengths of stay were less for voluntary agencies than all agencies combined. "Some HHS Office of Inspector General and intermediary officials further believe that the nonprofit HHAs are being forced to offer increasingly more services in order to stay in business," states the GAO report.

The savings generated by PPS and the changed incentives for providers mean that Congress does not need to consider a Medicare home health copayment. VNAA believes such a copayment would be bad public policy because it would:

o **Essentially create an unfunded mandate to the states.** Under current law, states are required through their Medicaid programs to cover coinsurance costs for poor Medicare beneficiaries under the Qualified Medicare Beneficiary (QMB) statute. States would then be required to pay the Medicare home health copayment for QMB beneficiaries. Imposing additional costs on state governments would conflict with S. 1, the unfunded mandate legislation that Congress passed last year.

o **Fall heaviest on Medicare's poorest and oldest beneficiaries.** For example, individuals over age 75 account for less than 50% of the total Medicare population, but comprise nearly 75% of home health beneficiaries. In addition, nearly 50% of home health recipients have low income and already spend an average of 17.1% of their income on health care. One-fourth of all home care recipients have incomes between 100% and 150% of the federal poverty level. Most home care patients will have been recently discharged from the hospital, and on the average will have paid $1,700 or more in the preceding 12 months for Medicare premiums, deductibles, and copayments even before the first home care copay comes due. A 20% copayment would mean average copays of over $900 in 1996 for these individuals, according to the National Association for Home Care.

o **Deter utilization among poor beneficiaries to the point that they might not seek medically-necessary care.** VNAs' experience has been that patients who can't afford cost-sharing forgo care in order to buy groceries or other necessities. While we would provide care to a patient regardless of his or her ability to pay, our experience has been that many of these individuals choose to hide a serious health condition rather than admit to not being able to afford the care. In 1994, the Office of Technology Assessment found that making patients responsible for copayments will keep them from seeking necessary care and could be especially harmful to those with low income.

o **Not deter utilization among those who could most afford to pay a copay.** According to Stuart Altman, chair of the Prospective Payment Commission, beneficiaries with Medicare supplemental insurance policies would have coverage for copayments.

o **Create a disincentive for patients to seek appropriate, less-expensive, home health care services.** Home health was exempted from the Medicare Part B coinsurance in 1972 in order to encourage utilization of less costly services. Reimposing a coinsurance would undermine that effort and create a financial incentive for institutional care. In addition, because there is no Medicare copayment for the first 60 days of inpatient hospital care, a home health copayment might result in longer hospital stays. Hospital patients can also stay within a hospital's transitional care unit beyond the 60 days without having to pay a copayment.

VNAA is also opposed to bundling post-acute care Medicare payments into hospital DRG payments. We believe such bundling would compromise the quality and accessibility of home care available to beneficiaries in the following ways:

o Hospitals have limited experience in determining cost for non-hospital, post-acute care; therefore, home care payments based on DRG rates would most likely not match patients' needs;

o Bundling would increase the administrative burden on home care providers by requiring multiple payment systems for home care -- one for post-hospital patients and one for patients entering home care from the community; home care agencies would be required to bill any number of hospitals for the care they provide to post-hospital patients rather than using the current single-billing system.

Finally, VNAA also urges you to oppose the Administration's proposal to limit Medicare Part A coverage of home health to the first 100 visits following a hospital stay and shift the rest of the benefit to Part B. VNAA opposes this "Part A to Part B shift" because it does not achieve true savings or target over-utilization as a per-episode PPS would do.

Conclusion

VNAA believes the industry's revised PPS plan will go a long way toward reigning in over-utilization. It will preserve access to high quality home health care while providing incentives for that care to be furnished in a cost-effective and efficient manner. By replacing cost reimbursement, prospective pay will create an incentive to providers to help a patient reach his or her highest level of wellness with the fewest visits and lowest cost. Quality, not quantity, will be emphasized, which will make home health services a better value for the beneficiary, the Medicare program, and the people of our country.

Revised Unified Proposal for a Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Revised Unified Plan for a Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 which was presented as an alternative to a Medicare home health copay and proposal to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home care PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out-of-pocket costs.

We invite your careful review of this proposal. If you have any questions or would like additional information, please feel free to contact the organizations listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202-547-7424

PPS Work Group
Jim Pyles 202-466-6550

3-28-96

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost-effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, resulting in an episodic prospective payment system plan that should:

- be developed cooperatively by HHS, the industry, and Congress
- be acceptable to the industry
- include extended care
- be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- be approved by Congress
- include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare Home Health services should be maintained with no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo- 30mo	48mo	60mo

IV. PPS Specifications

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be develop and implemented. The data base must be able to link case mix data withcost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB-92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rates and limits shall be adjusted to reflect cost of data collection.

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530).

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per Visit Payment

- standard per visit rate for each discipline calculated (as in HR 2491) as follows:
  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 months cost reporting period ending on or before 12-31-94 and updated by the home health market basket index, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) a HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- base year for payment rates and cost limits - 1994 (using settled cost reports)

Agency Annual Aggregate Per Patient Payment Limit

- base year for aggregate payment limit - 1995 utilization data for each agency

- the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit - updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data, then 50% agency data & 50% census region data

- the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central. West South Central, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate per patient cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limit. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

- Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode limit for days 1-120 (as in HR 2491) and an annual aggregate per patient limit for visits after 120 days.

- continue per visit payment as in Phase I

- an episode is 120 days; post 120 day care is paid per visit with an annual aggregate per patient blended limit for the post 120 day period that is separate from the 1-120 day annual aggregate episode limit

- the HHA is credited for a new episode limit if there is a period of 45 days without Medicare covered home health care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to the aggregate episode limit if within the first 120 days, or the separate post 120 day aggregate per patient blended limit if after 120 days).

- the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available

- the per episode limit (as in HR 2491) is equal to the mean number of visits for each discipline during the 120 day episode of a case mix category in an area during the base year multiplied by the per visit payment rate for each discipline

- the annual aggregate episode limit (as in HR 2491) is equal to the number of episodes of each case mix category during the fiscal year multiplied by the per episode limit determined for such case mix category for such fiscal year

- the region for the episode limit - MSA/nonMSA area

- the annual post 120 day per patient blended limit is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit updated, multiplied by 1995 utilization) and updated by the home health market basket index: calculation based 50% on agency data & 50% on census region data

- the annual aggregate post 120 day per patient blended limit is equal to the number of unduplicated patients receiving care beyond 120 days in the year multiplied by the per patient blended limit

- the current certification and coverage guidelines continue

Sharing Saving

HHAs that are able to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

Phase III *(as noted under the goal in Section I)*

Per Episode PPS

- developed cooperatively by HHS, the industry, and Congress

- acceptable to the industry

- includes extended care
- must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- approved by Congress
- adjustments for new requirements (such as OSHA) or changes in technology or care practices
- case mix adjustor that reflects the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. Exceptions: The Secretary shall provide for an exemption from, or an exception and adjustment to, the methods for determining payment limits when extraordinary circumstances beyond the home health agency's control including outliers and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system. The Secretary shall develop a method for monitoring expenditures when they are found to decrease total Medicare expenditures.

2. Quality: Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by implementing a revised survey and certification process that emphasizes patient satisfaction and successful outcomes.

   Home heath agencies will be required to provide covered services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

   There will be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through external PRO review.

   There will be established a mechanism for quality review for instances of significant variation in utilization by providers (this can address both visits and admissions).